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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Communications.

ON THE IMPROVEMENTS IN SURGERY.*

BY FAYETTE DUNLOP, M.D.

On reviewing the surgery of the past twelve months it is evident that no sudden leaps or brilliant achievements have marked its progress, yet in no sense has the zeal or spirit of surgical science been diminished. In every direction we find able, steady work being done, with the effect of gradually advancing this branch of science. Progress in the art of surgery is to be measured not so much by the rapid introduction of new plans and measures as in the firm establishment and more widespread use of means already recognized as of value. The avidity of the human mind for novelty is as well illustrated in the medical profession as in any other calling, yet among none is there more skepticism as to innovations and none which requires more intelligent experience to give new things a fixed place among its measures.

* Being the report of the committee on this subject read before the Kentucky State Medical Society, April, 1881.

The surgery of the kidney has within the past year attracted much attention, and the reports of operations both for incision and entire removal of this viscus have been far more favorable than was at first anticipated. This, no doubt, has been effected by the comparative safety with which the abdominal cavity can now be opened and its contents manipulated. Attention was first directed to ablation of the kidney by Simon of Heidelberg, who, accidentally dividing the ureter in an ovariotomy, at once removed the kidney to which it led, in order to prevent the disastrous results of the mishap. A number of subsequent experiments on the lower animals convinced the German surgeon of the practicability and value of the operation under certain conditions, and proved that the renal function could be adequately carried on by one kidney alone. During the past year this operation has been done in various parts of the world, and with much the same success which attends the removal of the uterus, ovaries, etc. Extirpation of the kidney, however, is not to be undertaken unless the remaining organ is satisfactorily performing its function. The operation is indicated in such wounds as threaten to prove fatal from hemorrhage, exhaustion, and suppuration which an incision has failed to relieve, calculous disease not curable by simple incision of the kidney, morbid growths, fistula of the ureter, etc. Two modes of doing the operation have been practiced—one the extra-peritoneal, the other by abdominal section. The choice is determined by the conditions which exist in each individual case. Incision through the lumbar region has so far been oftenest performed and with the best results, owing, no doubt, to the fact that in this region such exploratory incisions as may be required to determine the need of an operation are made with ease and with comparatively little danger. The operation is contra-indicated in carcinomatous and sarcomatous diseases, in cysts and burrowing abscesses. The removal of the kidney by abdominal section is done in a similar way to ovariotomy. The chief difficulty encountered here is as to the mode of disposing of the stump. The blood-vessels are so short that the clamp can not be considered. Tor-

sion and the catgut ligature have both been employed, the catgut being left in the wound with no untoward symptoms. Death suddenly occurred after the operation in one case. The autopsy revealed a large clot which had escaped from the stump into the vena cava. We know of no means for avoiding this risk.

Incision in the lumbar region for removal of calculi in the pelvis of the kidney has been successfully performed, but owing to the difficulty of diagnosis in these cases the operation has been attempted but a few times. On the whole, the success of both procedures has been encouraging, and they are now justly ranked among the established operations. Another year will probably find them often practiced.

The rapid adoption of Bigelow's operation, as it is called, and the very marked favor accorded to it, shows that the professional mind was ready for an improvement in this direction. Experienced lithotritists, the only competent judges, both in this country and abroad, have tested its merits, remedied in large degree such defects as were attached to the original instruments, and in a little more than three years since its introduction the operation is pronounced a most valuable addition to our means for removing stone from the bladder. By Bigelow's method a great number of vesical calculi have been evacuated at a single sitting from aged and infirm subjects with a comfort and safety far beyond that which could have been had either from the old lithotomy or under the knife.

To one familiar with the details of lithotomy the size and composition of the stone can be pretty generally determined, when the choice of the lithotrite becomes easy. The largest sizes are seldom required, and the careful surgeon will avoid them unless they be absolutely necessary; for the smaller the instrument the less likelihood of mischief. Because Bigelow's method proves so successful in the hands of those whose experience in lithotomy justifies its use as a test of its efficacy, it must not be understood that it will give like results in the hands of every one who may resort to its use. There is no doubt that lithotomy for a stone of large size is a safer measure in the

hands of one unfamiliar with the details of lithotomy than Bigelow's method. Even the general adoption of the new method will not altogether do away with the knife, for there are numerous conditions which preclude lithotomy; among them the size of the urethra, shape and hardness of the stone, and the state of the bladder. The chief and most important feature established by Bigelow is the tolerance of manipulation shown by the bladder. Hitherto it has been the belief among surgeons that the bladder will bear none but the gentlest manipulation without serious consequences. Bigelow has established that the bladder is exceedingly tolerant of at least all the injury which his method is likely to inflict. If the bladder is thoroughly cleansed of all debris, even though the mucous membrane has been wounded it readily heals, the failure to bring about recovery in the older methods being due to irritation by the sharp angular fragments. Special attention has been given to the matter, and convincing evidence of unlooked-for tolerance of the organ has been afforded by a sufficient number of cases. The adoption of the method has the further advantage of enlarging the range within which lithotomy is applicable, and it encourages the surgeon to deal with much larger stones than under former methods. What the limits of the operation as determined by the size of the calculus really are, further experience can alone decide; but the prospect of greatly diminishing the number of cases subjected to lithotomy on account of the dimensions of the calculus—a class in which the mortality is especially great—seems almost certain to be realized. Experience has proved the truth of Bigelow's maxims in the main, and we can with security look for the general adoption of the plan he has devised. Its imperfections being recognized, another year will perhaps record their removal. Any new device that fails to meet the general approval of the profession, and the use of which is limited to a few specialists, will usually fail of adoption and fall into disuse. It is the confident expectation of your reporter that but few years will go by ere the lithotrite and exhausting-bottle will be found in the armamentarium of the village surgeon, and with

further experience the results of their use will be better than at present. Sir Henry Thompson, who has done more lithotrities than any one else, lends Bigelow's method the sanction of his great name, and states it to be an advance in lithotritry. Billroth too accepts it and gives it his unqualified indorsement.

Prof. Esmarch has somewhat modified the manner of applying the rubber bandage and the subsequent treatment of wounded surfaces. He no longer at once removes the constricting tube, but first ligates the bleeding vessels and brings the edges of the wound together with deep sutures, and keeps the limb in an upright position for half an hour. He then makes the permanent dressings and puts the limb in the horizontal position. A sufficient number of cases have already been treated in this manner to prove that secondary hemorrhage is rare, while there are many advantages in the matter of time, cleanliness, etc. Esmarch prefers the simple dry dressing to any other, and allows it to remain twelve or fifteen days without removal.

Operations for the correction of deformities in the bones have been repeatedly performed during the year with a success which will still further stimulate those surgeons who live where such diseases exist. There are already those, however, who think they see that practice in this direction has exceeded its proper limits. However this may be, we know that many deformities arising from constitutional causes, and which were until recently regarded as irremediable, are now, by the genius of modern surgery, overcome, and limbs and joints made useful and comely which were before misshapen.

Since ovariotomy revealed the extent to which the pelvic and abdominal organs can be manipulated without fatal results, it has also been attempted to remove tumors of the uterus, and even that organ itself. In the removal of simple myomata the results have been proportionately favorable. The extirpation of the uterus for carcinoma or any variety of malignant disease, proposed a few years ago by Freund, has been the subject of earnest investigation during the past year. At no period since its beginning has the prospect of its adoption been hopeful,

and at the present writing it is gloomy indeed. Various methods have been tested, each suggested by the conditions indicating the operation, but as yet no real advantage can be claimed for the one over the other. The results, whether the organ is taken out through the vagina or by abdominal incision, are about the same; which the operator will select is governed largely by varying circumstances. Schroder, who seems to have had the most satisfactory results, all things considered, adopts the vaginal incision, and claims that it is more easily and satisfactorily performed; the shock is not so severe, and the danger from either primary or secondary hemorrhage far less than by the abdominal incision. The chief difficulties heretofore encountered have been to control hemorrhage and dispose of the stump. Quite a number of cases have borne the shock of the operation well, escaped pelvic peritonitis and abscess, and finally died of slow secondary hemorrhage into the abdominal cavity. As regards the indications, in the first place many cases do not occur in which the entire uterus must be extirpated. The operation should not be performed when carcinomatous disease exists in the pelvic connective tissue. Not only extensive infiltrations, but quite small nodules in the folds of Douglas's cul-de-sac form a contra-indication. Where only the body of the uterus is invaded, and entirely above the internal os or vaginal junction, removal by laparotomy, and only so much of the organ as is involved, is the chosen operation. Total extirpations are called for when the cervix is affected and the vaginal walls, and all the cellular tissue involved must come away. In this way the measure finds its limits; if the disease has gone too far, operation is impossible. Of course it is plain that a procedure involving so many risks and the benefits to be derived of a character so questionable will fail of general adoption, while its performance must rest in the hands of a few gynecologists.

There is no part of the surgical practice instituted by Mr. Lister which has more interest than his reintroduction of the animal ligature. A number of recent experiments by Arnaud

in Paris and Lister himself fully demonstrate the truth of the belief long ago expressed by the friends of the antiseptic practice, namely, the complete absorption of the animal ligature. It is further claimed that the outer coat of the artery is not ulcerated as by silk and hemp, but that the knot becomes loosened before that process begins. While clinical experience and numerous experiments have done much to favor its use, the opinion of the profession is far from unanimous. The desire for a ligature which would not act as a source of irritation has long been a dream of the surgeon, and seems now about to be realized. With a view to ascertain the rate and certainty of absorption of catgut of different preparations, Prof. Lister thinks he has now established the catgut as the ligature of the future. Imperfections in its preparation and its use in unsuitable cases may explain a part if not all of the failures which have attended its employment, and we grant that some improvement in its preparation is still demanded. The difficulty of preventing the knot from untying from prolonged immersion in blood and the secretions of the wound seems now to be averted by a method of preparation devised by Lister. This method can be found in the London Lancet of January 22, 1881.

We approach now that portion of our report which has been the field for more earnest debate and diversity of opinion than any which has ever occupied the surgical mind; namely, antiseptic surgery. The treatment of wounds now, as it ever has, occupies a considerable share of attention; and though surgeons are as little agreed as to the methods and details to be employed, yet they are more and more one as to the object aimed at. Antiseptic surgery is practiced or claimed to be practiced by nearly all surgeons, and it is safe to say that their success or failure is in a great measure governed by their preconceived idea of its efficacy. Whatever advantages this popular surgical procedure may possess, there can be no question that it is in danger of being brought into disrepute, solely from an unintelligent manner of its use; and unless some uniform method is soon decided upon it can not fail soon to fall into ill-favor, as the term

of its probation has been one of unusual length before the profession. No more deplorable reputation could befall Listerism than that of infallibility, which would absolve the surgeon from further responsibility and from that zealous care which the former method imposed. While no advance can be recorded for this department of surgery, it is much to say that it has lost none in favor, and its champions are as active as ever and constantly strengthening their position with the impregnable fortification of success where it is claimed failure would have been recorded. In the matter of rendering its details and application more simple and within the power of all, there is a disposition to do away with the spray as useless and in no way adding to its good results. It is claimed, and seemingly with reason, that in peritoneal incisions the spray is irritating, the rapid evaporation induced by it too cooling for the exposed intestines, and that poisonous quantities of the acid are absorbed in prolonged operations. The proceeding is yet too new to be universally adopted, and has too much in its favor to be hastily condemned on the authority of a few. Not until the present enthusiasm and thirst for notoriety of its advocates have given way to the irresistible logic of facts can we hope for unprejudiced, calm decision of its value.

The success which was stated to have followed the administration of Chian turpentine in cancerous disease was so marked that more than ordinary notice was at once directed to it. It was introduced under the sanction of the well-known name of John Clay, of Manchester, and claimed by him to be palliative if not absolutely curative in cancerous affections, particularly those of the generative organs. So far the hope so often kindled and as often disappointed has failed to be realized in Chian turpentine after thorough and intelligent test of its value. The cases in which it is reported to have been of benefit are open to the fatal objection of not being cancerous in their nature; that it has surely failed in undoubted cases of cancer of the uterus; and its supposed success is due to the fact of the difficulty of diagnosis of malignant disease of the generative organs in its early

stages. We risk nothing in asserting that Chian turpentine will be entirely discarded as a cure for malignant disease, the hopes and expectations centered in it dissipated, and the eyes of the profession turned in another direction in search of the long-hoped-for discovery.

The pages of surgical literature have been filled with valuable contributions, embracing every department of the surgeon's duties. The ill effects of the pursuit of any specialty to the utter exclusion of a general study of surgery has been dwelt upon and deprecated by all who have given the subject attention. About the average number of works on surgery, with the revision of some of the older and most acceptable ones, have been issued, showing plainly no lack of zeal in the endeavors to advance the interests of surgical science.

DANVILLE, KY.

A CASE OF OVARIOTOMY.*

BY W. O. ROBERTS, M.D.,

Demonstrator of Anatomy, University of Louisville, etc., etc.

Mrs. M., aged fifty-nine, mother of six children, the youngest twenty-three years old, has not menstruated for fifteen years. Three years ago general health having been good with exception of occasional severe attacks of flatulent colic, she noticed for the first time a tumor about the size of a cocoanut situated in the side of her abdomen, which increased until October, 1880, when it completely filled the cavity. I now saw the case in consultation with Dr. Cox, and found her condition as follows: Abdomen greatly distended, with marked prominence of superficial veins, fluctuation elicited by percussion, respiration considerably interfered with, feet and legs slightly swollen, appetite much

* Read before the Kentucky State Medical Society, 1881.

impaired, sensation of great fullness and difficulty of breathing following meals, bowels constipated and much pain in back and legs caused by slight exercise. Ovarian dropsy diagnosed, and to give temporary relief the cyst was tapped, and two gallons of thick, greenish fluid were drawn off. Patient remained in bed but a day after the paracentesis, got up and attended to her household affairs, but for days had soreness and tenderness of abdomen. The cyst soon began to refill, and by December 15th appeared as large as before tapping. She now consented to removal of the tumor, and was sent to SS. Mary and Elizabeth Hospital to be prepared for the operation. In the latter part of the month she was seized with what she considered one of her old attacks of colic, the symptoms of which were as follows: Great pain and tenderness over whole abdomen, with some increase in its size, excessive vomiting, pulse weak and irregular, expression anxious, surface of body pale and cold, voice husky, bowels constipated, and urine scant and voided with great difficulty. This condition was followed for several days by slight fever, during which the tenderness and pain in abdomen continued, while the urine was scant, high-colored, and had required to be drawn off. She recovered from this attack very slowly. She was confined to bed for ten days, and was unable to get about her room for some weeks.

On March 2d her condition had so much improved it was decided to operate. This was done under strict antiseptic precautions, Prof. D. W. Yandell, Drs. Cox, Cottell, and others being present. On opening the peritoneum a considerable quantity of turbid serum escaped. Adhesions were found connecting the sac to the omentum anteriorly and abdominal walls posteriorly, the separating of which was followed by some hemorrhage. The sac was multilocular, and contained twenty-six pints of a thick, greenish-colored fluid. Pedicle broad and short. This was ligated with silk, cut, and returned. Intestines were coated with newly-deposited lymph. After thoroughly cleansing the cavity, wound was closed with silk-worm sutures, the patient was placed in bed and given an opiate, to be repeated in two

hours if in pain. First hour after the operation pulse 90, temperature 98° , great pain in abdomen, had vomited the anodyne. A half grain of morphine hypodermically was soon followed by complete relief. From now on patient recovered without one bad symptom. Her temperature never exceeded normal except on the third day, when it reached 100.7° . During the first three days there was some vomiting—not excessive—during which time she took Vichy water and crushed ice alone. One fourth of a grain of morphine was administered every six or twelve hours for the relief and prevention of abdominal pain. The dressing was not disturbed until the seventh day, when the wound was found completely healed, and the stitches were removed. The patient sat up in bed on the tenth day, and was anxious to get up, declaring that she felt better and stronger than she had for months. This, however, I need not say she was not allowed to do until the end of the third week.

LOUISVILLE.

IS TYPHO-MALARIAL FEVER A DISEASE PER SE?

BY RODNEY T. TRIMBLE, M.D.

It is scarcely necessary to say that the term typho-malarial fever is used to designate a fever which is thought to partake of the character of both typhoid and malarial fevers, and was coined, I believe, by Dr. Woodward.

Professor Loomis, in describing typho-malarial fever, admits two principal types, the typhoid and the malarial. He follows closely Dr. Woodward as to the intestinal lesions, but differs with him as to the etiology of the affection. Prof. L. says, "It is difficult to determine the true etiology of typho-malarial fever, but that malarial poison is necessary for its development there can be no question. It is equally certain that some other poison is

in operation whenever the fever prevails; that this poison is not the specific poison of typhoid fever. There are two or three facts connected with its development which are now well established: First, it is only met with in malarial districts. Second, in the majority of instances where this fever has prevailed, its development has been preceded by marked and readily-recognized anti-hygienic conditions, such as overcrowding, bad sewerage, and other conditions favorable to the development of septic poison. Third, that it is a non-contagious disease, and is never propagated from the diseased to the healthy, either directly by personal contagion, or indirectly by morbid excretions."

The doctrine of Dr. L., then, is briefly that there is a disease manifested by constant and characteristic symptoms produced by the combined effect of malarial and septic poison; that it is entitled to a name as a distinct disease; and finally, that it has certain characteristic lesions of the intestinal tract, particularly of Peyer's patches, different from those observed in typhoid fever.

Septic poisons may mean a great deal in the broad sense in which Professor Loomis uses the word. No doubt septic poisons are produced within the body itself by the retrograde metamorphosis of tissue, or they may in various forms be absorbed from without. In either case, malaria may exist simultaneously in the human organism and be modified by such influence; but where the factor, septic poison, is so variable, the symptoms surely could not be constant and characteristic except as pointing, perhaps, to the typhoid state. To such a condition we are hardly justified in applying a new name; it should, I think, be considered not a new disease, but a form of malarial fever. Professor Loomis himself does not regard it as being a new disease, for he says, "It can not be regarded as a new disease, but in its morbid anatomy and symptomatology is a combination of two well-recognized forms of fever. The special symptoms and lesions of one or the other of these fevers stamp its character and indicate its alliance to a malarial or septic type of fever."

It would appear that the reference to the morbid anatomy in this quotation does not correspond to the previous statement

that typho-malarial fever has certain characteristic pathological lesions. Prof. L. says he follows Dr. Woodward closely in his description of these lesions, and that, according to Bartholow, Woodward has changed his opinion as to the existence of such lesions, and quotes Dr. Woodward as follows:

"The autopsies of these cases (typho-malarial fever) disclosed the ordinary lesions of typhoid fever. During my earlier studies I believed that I had observed certain peculiarities in the character of the ulcers in these cases by which they might be distinguished from the lesions of simple typhoid. A larger experience, especially examination of a large number of specimens received by the medical section of the Army Medical Museum, has convinced me that this opinion was premature. I renounce it as erroneous. There is really nothing in the lesions of Peyer's glands in these cases to distinguish them from ordinary cases of typhoid fever."

After this, I must believe that the cases described by Professor Loomis as exhibiting such lesions, were cases of typhoid. According to our view, Professor Loomis embraces under the term typho-malarial two distinct forms of disease—malarial fever and typhoid fever.

The theory as to the union of the two poisons is the one I believe generally held by those who claim that typho-malarial fever is a disease *per se*. It may be stated thus: The two poisons (typhoid and malarial) are present in the system and in active operation at one and the same time, so modifying the effects the one of the other as to produce symptoms so constant and characteristic that they are collectively entitled to be called by a new name. This doctrine, coming with the weight of authority, deserves attention. That two or more specific poisons may infect the system at the same time is doubtless true, but generally in this case one only is active at a time. Among other instances given to illustrate this, is mentioned vaccination, which being performed on persons sick with measles the vaccine poison remained latent and took effect only after the measles had finished its course.

The eruptive fevers are usually met with as distinct and separate affections. Shall typhoid fever alone be considered the exception? I am aware that all these affections are influenced by circumstances to a certain degree, but only to a degree, their identity never being completely lost. Even malarial fevers, though they may appear under several forms, still in each the type is sufficiently clearly preserved to show that they all have a common origin. Malaria differs from the other infectious poisons mentioned in that it is not self-limited; in its action it tends to chronicity, and hence more than the others to create a peculiar diathesis. Its modifying effect in this way over other affections is clearly established. No one who has practiced in a malarial region can doubt the specific utility of quinia in most of the acute diseases he encounters. It is easy to understand how malaria may even have a great deal to do in producing a variety of acute diseases, such as pneumonia, hepatitis, splenitis, etc. Malaria often, in fact constantly, has local manifestations. But in acute infectious diseases the effect of malaria in modifying their course is much less apparent. Descriptions of the eruptive affections by one practicing in a malarial region very widely differ from those drawn by one who never met the marsh poison. It will be observed that I do not deny that one disease may be modified by another, especially when that disease is malarial. I wish merely to narrow the limits in which this occurs.

Trousseau held correctly that one disease can not be converted into another, though for a time they may assume the features of another, especially in the instance of epidemic influences, but identity is never lost.

It is well also to remember that when the course of a disease is not exactly typical it is not logical to suppose there must be another specific poison at work. There are many other influences besides specificity, as amount of poison, vitality of subject, age, sex, etc. That the special poisons of typhoid and malarial fevers may manifest themselves at the same time in the same subject, may be answered in the affirmative, this view being supported by Dunglison, Wood, Flint, and Da Costa. Trousseau

virtually admits it, and Hertz (*Ziemssen's Cyclopaedia*), does not deny it. But that the simultaneous manifestation of the two diseases is of frequent occurrence has given rise to great difference of opinion.

My own very limited experience corresponds with the following quotation from Hertz: "The same thing does not hold true in regard to typhoid fever, the epidemic appearance of which is not often simultaneous with that of intermittent fever. I do not assert a complete mutual exclusion as to time and place between these two diseases; but this much I can declare from my own experience, that in Amsterdam, where all forms of malarial fever are indigenous, typhoid fever is among the greatest rarities. The annual statistics of two thousand cases of sickness in the division of medical diseases show barely one or two cases of typhoid fever.

When the two diseases do manifest themselves together, what is the result? Usually but to mask for a time the typhoid disease by certain malarial characteristics, the case becoming more clearly defined typhoid as it advances. The peculiar symptoms, however, are neither so constant nor marked as to justify a new name or regarding the condition as distinct disease capable of being diagnosed as such. I agree with Bartholow, that the term typho-malarial tends to encourage carelessness in diagnosis. Even the most obscure cases can, as a rule, be finally shown to be either typhoid or malarial—one, not both. All the cases I have met with called typho-malarial were, in a specific sense, malarial simply without any typhoid. And I think the disease called Chickahominy fever, and which Dr. Woodward describes under the name of typho-malarial fever, was clearly malarial. I am confirmed in this opinion by Dr. Manson, of Richmond, Va., who, in describing the malarial fevers of his section of country,* speaks of continued malarial fever with typhoid symptoms, but as entirely distinct from typhoid, and capable of being diagnosed from it, but who nowhere mentions a disease produced by the union of the two poisons.

* *Richmond and Louisville Medical Journal*, August, 1871.

In regard to my own experience. I practiced for a few years at Hillsboro, Ohio, a place then remarkably free from malaria. There I frequently met with typhoid fever, having in a local epidemic seen as many as eighteen cases in quick succession in a negro settlement. In these cases, in spite of the negative evidence furnished by the dark skin of the negro as to rose-colored spots, I am clear that the disease was simple typhoid fever in every instance. They were carefully watched. A record was kept of the temperature and all important points. The tendency to spread locally by contagion, in the general sense of the word, was strikingly manifested, and the disease was confined to the same locality throughout its prevalence. At New Vienna, where I have lived for the past nine years, malaria prevails in all its forms. My experience here with typhoid fever has been much less extensive than at Hillsboro. In every single instance where it has prevailed it has clearly been imported, and save in one has spread by infecting those who had the immediate care of the sick.

The first case at Vienna occurred in 1873 in the practice of another physician, and was imported in the person of an insane young man from Dayton, who came home sick with the disease. The difficulty, which at first was great, owing to the previous history, was to diagnose the disease from dementia resulting from gradually increasing brain-trouble. The case, however, soon became clear, and several other members of the household were seized with genuine typhoid. After this the disease did not occur again for four years, when in April, 1877, a young lady returned from college sick with the disease. Here my diagnosis as to the nature of the case was confirmed by Dr. Morey, who has had a very large experience in the malarial fevers of this region. The case was a typical one, even to the rose spots. The disease infected several different families, spreading from those living at the house to other and somewhat distant households. There were four or five cases to be directly traced to this single point of infection. This may be explained by the fact that before the patient came under obser-

vation a privy was used in common by the household to receive the alvine discharges.

In the following July the disease reappeared in Vienna for the last time. A young man returned from Cincinnati with typhoid fever and furnished the only case out of those I have mentioned in which there were malarial symptoms of note, yet even here I think there could be no question of the accuracy of the diagnosis, for although in this instance other cases did not follow, the explanation is, I think, to be found in the fact that being seen immediately on its arrival the alvine dejections were disinfected and buried.

I regard the foregoing account of typhoid fever as being interesting from the fact that in every instance it could first be traced to importation and its subsequent spread by contagion from the alvine discharges of the sick. The history further shows how little the symptoms were, as a rule, influenced by malaria, though this is constantly present in the locality. Not only were the typhoid fever cases readily diagnosed after a short time, so marked were the symptoms, but it was observed at the time that cases of malarial fever did not then nor afterward assume typhoid symptoms. It will be understood from what I have said that my experience in malarial diseases has necessarily been considerable. Marsh fever in its various forms I have seen over and over again, and I have not infrequently encountered it as a continued fever. The type has sometimes been very grave, early producing the typhoid condition, especially when the temperature remained high for any considerable period. It is interesting to note that the mortality in this class of cases has been greater than in typhoid fever proper; also that cases of this description were called, in my section, typho-malarial. It is my belief that the same error is made elsewhere.

In no instance in my experience have the characteristic symptoms of typhoid been present, and in no instance has the disease spread by contagion, though no care whatever was taken to disinfect the alvine discharges. Nor has it been confined to any particular locality, while quinine has generally shown its specific

power if not fully at least to some extent. If the typhoid poison had any thing to do in developing the disease in any case, it certainly was shorn of its most prominent characteristics, and could not be recognized by its work. For my part I believe it much more rational to look for the operation of other influences, as high temperature, etc., producing the typhoid condition than to charge it to the specific germ—if I may so call it—of typhoid fever.

For my own part, I am clearly of the opinion that the affection called typho-malarial fever is not a disease *per se*; that the term is usually applied to a simple malarial fever which has assumed a continued type; and finally, that the name is unfortunate, as leading to confusion, and tempting, as has been remarked, to carelessness in diagnosis. Typho-malarial fever is a well-sounding phrase, and often convenient to use, but is it strictly scientific?

NEW VIENNA, O.

FOUR ENUCLEATIONS OF THE EYE.

BY IRA A. E. LYONS, M.D.

The present method of enucleation was devised in 1841 by Bonnet and O'Ferrall, independent of each other. It was introduced in London in 1851 by Mr. Critchett. The great advantage in this method is removal of the eye from the ocular capsule without any injury to or interference with the cellular tissue of the orbit or a division of the outer commissure of the eyelids. The muscles are divided quite close to their insertion in the sclera, the conjunctiva preserved, and as but few blood-vessels are severed the hemorrhage is but slight, and you have an excellent stump for an artificial eye. Enucleation of the eyeball becomes necessary by the presence of foreign bodies in the eye, or other injuries, by staphyloma, sympathetic irritation,

and other diseases. The following cases are those occurring in my clinic at the Central College of Physicians and Surgeons during the winter term of 1880-81:

CASE I. J. P., physician, age fifty-six. For the last twenty-five years the eyes have been failing, the result of some inflammatory action in the uvial track. The eyes are both staphylomatous. With the right can just see enough to read and go about; but in the left, both quantitative and qualitative perception of vision are lost; the eye was painful and constantly inflamed, which affected the other to a greater or less amount. In hopes of improving sight in the other by relieving it of this constant source of irritation, I practiced enucleation. The ball was found to be increased anterior posteriorly; all the coats attenuated; detachment of retina; the lens opaque and in contact with posterior surface of cornea; the iris completely degenerated and rotten. The cornea was dotted over with opaque spots, the result of former inflammation, between the different layers. The removal has not increased vision any, although he *thinks* he sees better. The ball is not so liable to those "spells of irritation," and the danger of losing "what sight he has" is not so great. The presence of an artificial eye does not cause any sympathetic trouble. The case was undertaken simply to ameliorate, if possible, the present symptoms of irritation and to save the little remaining sight.

CASE II. O. J. R., age thirteen. Was brought on account of a constant discharge from the eye for ten years. Had tried many doctors without any good. The history of the case was this: When three years old fell out of a window and ran a stick into his eye. The doctor removed several splinters, but the eye had been destroyed, and there began a discharge which would not be controlled by local applications. When brought to me the eye presented the following appearances: The ball red and inflamed, cornea hardly distinguishable; could not be moved in any direction, and the movements of the other eyeball were also restricted in consequence. The cornea was turned inward, as in a bad case of squint, except in squint the eye can be turned out-

ward, the other making an associated movement inward; but here the ball remained passive. After seeing the case a couple of times, was convinced there was still a foreign body in the orbit; if not, why this persistent discharge and interference of mobility of eyeball? I discouraged local treatment, and insisted on enucleation, which the boy heartily favored. On December 2, 1880, Professor Eastman administering the chloroform, I proceeded to remove the eyeball. Had no trouble until I came to internal rectus, when I found it impossible to get the muscle on the hook so as to cut it off. My scissors met with some hard substance, and it was not until after I had pulled the ball off of the end of the foreign substance that I was able to finish the operation. In trying to get the muscle on the hook the eye turned outward, at the same time the vitreous escaped, the ball collapsed, which complicated its removal. After the removal and inserting my finger, it met with this resisting substance, which on taking it away proved to be a stick of pine one and a half inches long and one quarter inch in diameter. It had been there ten years.

When the patient fell out of the window the stick struck the ball external to the cornea, and passing through it turned the cornea inward, and thus created apparent cross-eye; but after a couple of days the external rectus acting drew the ball outward, and so left one end of the stick inside of the ball, the other running inward and backward, penetrating the ethmoid cells, and so held the ball just as though a nail had been driven through the ball into the skull, thus transfixing it.

The boy is now attending school and has better use of the other eye. The discharge has ceased. In looking into the socket inward and backward one can see half an inch into the channel that the stick made.

CASE III. Mr. O. K. C., age sixty-five. Blind in right eye, while the other eye gives him so much trouble as to prevent him attending to his usual avocations and reading the daily papers. The history of the case is this: While where his children were playing base-ball the ball struck him in the eye,

causing detachment of retina, with subsequent traumatic cataract and strong tendency to sympathetic irritation. There being no probability of any relief as long as the diseased eye remained, advised enucleation, and on the 20th of January, 1881, did the operation. The patient is now attending to business in entire comfort, and is greatly improved in appearance by an artificial eye.

CASE IV. Mr. C. B., age twenty-three, twelve years ago was struck in the right eye by a bit of a gun-cap, the fragment entering the ball and lodging in the ciliary muscle, there to become encapsulated and remain until the day the eye was removed. The eye was very painful for several weeks after the injury, but it seemed to improve; the pain finally disappeared, but the eye was totally lost, and it never ceased to be a source of trouble and irritation. When I saw him fresh inflammation was setting up and the eye was very painful. There were strong symptoms of sympathetic irritation. Advised enucleation without delay. The operation was performed on January 27, 1881, since which time patient has been free from trouble. The ball was atrophied, and the foreign body was found imbedded in the ciliary muscle.

INDIANAPOLIS.

AN ANEURISM OF FEMORAL ARTERY.

BY W. F. STIRMAN, M.D.,

Assistant Physician to St. Louis City Hospital.

M. K., age twenty-eight, on the 14th day of September, 1879, had a pistol go off in his pocket. The ball, after passing through the ulnar side of palm of left hand, entered the thigh to the inner aspect of its anterior face, just below Poupart's ligament. It ranged downward and outward, and lodged under the skin in the outer and upper part of the popliteal space,

whence it was removed by the patient himself. He lost but little blood, and this from the hand, and missed but two days from work at the time. He continued in his usual health and at work until July 15, 1880, when the foot and thigh, especially the foot, became painful. In the evening the whole limb appeared to be swollen, and grew exceedingly painful during the latter part of the night. The swelling was most marked on inner side of thigh, immediately above knee, and gradually increased. The leg became somewhat flexed on the thigh. Constant pains set in, extending to the foot. General health continued fair.

On admission to hospital November 10, 1880, a tumor larger than a man's head was seen on inner and anterior part of thigh, extending from Poupart's ligament to the knee. The skin covering it was discolored and glossy, being apparently about to break down. Drs. Hodgen, Dean, and others examined the tumor and pronounced it an aneurism of the femoral artery. No pulsation could be either seen or felt. Thrill slight over lower part of swelling. Bruit distinct over whole tumor, and particularly over inner portion of lower third.

Dr. Hodgen operated under five per cent carbolized spray. He commenced the incision three inches below Poupart's ligament, and followed the track of the artery downward a distance of eight inches. A clot of from five to seven liters was turned out, disclosing a wound the size of a crow-quill in the femoral artery just where it enters Hunter's canal. Ligated the artery above and below and divided it. Adherent clots were not removed for fear of causing unnecessary hemorrhage. But a small amount of blood was lost, and most of that came from two subcutaneous veins which were overlooked in the hurry of the operation. Stuffed wound with antiseptic gauze wet with a two-and-a-half-per-cent solution of carbolic acid. On removing dressing twenty-four hours after, a profuse discharge of a seropuruloid fluid mixed with clotted blood escaped. Pulse and respiration good. Slight fever.

November 14th. Vomited twice; felt depressed; slight fever; bowels regular.

Six days after the operation the clots had all detached and the cavity was filling up with healthy granulations. Some fever still present. The temperature of the limb rose to the normal fourteen hours after the operation. The leg continued a little edematous and the foot painful. Antiseptic dressings were continued, always being applied under the spray. After the first few days the discharge was never profuse, and, owing to the carbolized dressings, but moderately offensive. The wound filled up rapidly, the general health improved, and on January 30, 1881, he was discharged from the hospital "well."

This case illustrates well the beneficence of carbolized dressings. When we take into consideration the extent of the wound, the fact of the fever never having been high, the non-disturbance (with the exception of one day) of alimentation, and the rapidity of the cure, it is to my mind a most remarkable case, the good features of which I can but attribute principally to Listerism."

ST. LOUIS, MO.

TWO CASES OF COMPLICATED FRACTURE OF THE HUMERUS WITHOUT ANCHYLOSIS.

BY GEO. N. MONETTE, M.D.

I saw shortly after the accident a young man who had, as the result of direct violence, received a fracture of the humerus involving the internal condyle, olecranonid cavity, and separated the internal condyle from the shaft of the bone. Shortly afterward I met with a case identically similar as to the seat of the fracture, due to a fall from some height. The tumefaction was very great in both cases. The two were treated in the same way, viz. continued applications of a lotion of hydrochlorate of ammonia (half ounce to one pint water) until the tumefaction had subsided—which was in ten days, when the parts were put

in plaster bandages. On removal of the dressings no ankylosis nor any complication of the joints existed, save an awkward inability to flex the arm readily, which passive motion soon obviated. In one of the cases subsequent to discharge there developed a species of deformity which evidently was due to an excessive amount of *callus* in the olecranoid cavity, causing some impediment to extreme flexion of the arm.

NEW ORLEANS.

FOREIGN CORRESPONDENCE.

My Dear Vandell:

LONDON, May 15, 1881.

The piercing northeast wind to which I bitterly alluded in my last letter is no doubt responsible to a great extent for the irreparable loss the British nation has sustained by the death of Lord Beaconsfield. Shortly after I dispatched my letter the weather became milder, and almost immediately the bronchial symptoms became less urgent, the patient was able to take and digest nourishment freely, and it began to seem as if the crisis was past. But the wind backed again to the northeast, and within a few hours the bulletins announced a relapse from which he never rallied. In a purely medical letter like this, a word of criticism as to his policy and aims would be completely out of place; besides, the daily press has repeated on this subject every hackneyed phrase and claptrap sentiment more than *usque ad nauseam*. Many years hence we shall be better able to judge of his policy; and whatever be the judgment passed, his name will undoubtedly always rank among those of the greatest of our statesmen.

The flat refusal of Sir W. Jenner to meet Dr. Kidd in consultation on his lordship's case has raised a storm of controversy which will subside as such controversies usually do, leav-

ing every one with precisely the same opinions they had at first. As to Dr. Quain, *laudatur ab his, culpatur ab illis*; and by *illis* I mean particularly the College of Physicians. With that learned corporation it is understood Dr. Quain's position is seriously damaged. So strong was the feeling against him among the fellows of the college that I hear, on excellent authority, at the ballot the other day for the election of a president one of the papers taken out of the ballot-box was found to bear the name of "Professor Ambidexter." Before the ballot a meeting was held, at which Dr. Quain tried to justify the course he had taken before the fellows, and after him Sir William Jenner spoke in explanation of his refusal to meet Dr. Kidd on any terms. "If Dr. Quain was right," said Sir William, "then I am wrong and deserve the censure of the college." The answer to these words was given in the ballot that followed, when Sir William Jenner was almost unanimously chosen as president. To me indeed it seems that Dr. Quain has been somewhat hardly used. Before he decided on going to see Lord Beaconsfield he took the advice of the most eminent and respected members of the profession, Sir James Paget and Sir Thomas Watson, and with their approval he undertook the case. It can not be held for an instant that he met Dr. Kidd in *consultation*. In a letter written to Dr. Quain Dr. Kidd's own words are, "Every prescription and order of yours shall be faithfully carried out by me." This is not much like a consultation. Moreover, Dr. Quain at once appointed his own lieutenant, Dr. Bruce, and installed him at the house in close attendance on the patient; so that Dr. Kidd's position was purely nominal. Under these circumstances I think not a few of the profession will hesitate before they condemn the course of action taken by Dr. Quain, while with the laity undoubtedly he has gained immensely in popularity and Sir William Jenner has somewhat lost ground.

Next to the death of Lord Beaconsfield the topic of the hour is the smallpox outbreak. It is useless to try and deny any longer the fact that we are face to face with a most serious epidemic. The number of fatal cases has been steadily increasing

during the past few weeks, and rose last week to eighty-four. The few hospitals that we have available for the reception of smallpox cases are full to overflowing, and when the disease once gets hold of the teeming courts and alleys it will be very difficult indeed to arrest its progress. Absolutely nothing in the way of prevention is being done by any of the numerous vestries and boards appointed for the waste of public time and money. It is said that government has in contemplation a bill to deal with the question of smallpox hospitals, but it seems likely that before government has finished "contemplating" the time for prevention will be past and a panic will have set in. In the south of London, where the epidemic is really most serious, it is a monstrous thing that children whose families are now suffering from the disease should be compelled to attend the public schools. Such blind folly is almost incredible, but it is, alas! true. Happily vaccination and revaccination are going on vigorously, so vigorously indeed that there is quite a lymph famine; and I have heard of several practitioners who have paid five shillings for a single tube of the precious fluid. An office has been started where the public may be vaccinated from the calf direct, and from what I hear the arrangements seem to be very good and careful. It is a private venture, and the profits are said to be very large. Of vaccination with calf lymph I have scarcely any experience, but as today or tomorrow I intend to be revaccinated, together with all my family, I shall in my next letter be able to report upon the result in several cases. However, the results of revaccination must necessarily vary considerably.

I have referred more than once to the treatment of locomotor ataxy and other diseases by nerve-stretching, cases of which have been detailed in the various medical journals. For some weeks past these reports have ceased to appear, and I have heard rumors that the results of such treatment after all are not quite so favorable as they at first appeared. Indeed I heard yesterday of a case in a west-end hospital of locomotor ataxy treated by stretching the sciatic nerve in which it had taken six weeks

to heal the incision, and the general symptoms seemed to have been much aggravated by the operation. I shall take every opportunity to ascertain the effects of this procedure in other cases. It was in Germany that this line of treatment was first adopted, and it is not very probable it will ever make much progress in this country. Germany possesses some of the most distinguished surgeons of the age, but also it is a country which has always been prominent for startling novelties in medical and surgical treatment, and the tendency in this direction seems to be increasing. One reads of the most unheard-of operations. Some obscure forms of spinal disease have been treated by *stretching the optic nerve*. The results are not mentioned, but they can, I think, be imagined without much difficulty. Scarcely less extraordinary are Professor Billroth's resections of the stomach of which three cases were brought forward at the late German Surgical Congress. Indeed the aim of modern German surgery appears to be to ascertain precisely with how much of its anatomy the human frame is capable of dispensing without too much disturbing that state of equilibrium called life.

An interesting therapeutical fact has just been referred to by M. Cornil, of Paris, in the *Revue de Therapeutique*. He states that when cantharides is applied to the skin of a rabbit, as by a blister, poisoning is produced, characterized by cystitis, nephritis, and inflammatory lesions in the liver and lungs. If the cantharides is injected, in twenty minutes after the operation great changes are found in the cavity of a glomerulus of the kidney. Abundant leucocytes are found between the envelope of Müller's capsule and the vascular bundle which composes the malpighian glomerule; besides this a granular exudation is found in the uriniferous tubes which fills and obliterates their caliber. In fact a true catarrh of these tubes is brought about. In the bladder the disturbances are nearly of the same kind, but the lesions are superficial, the irritating principle of the cantharides has acted directly on the internal surface of that organ. In the lung the small bronchial tubes are filled with white corpuscles; these lesions which indicate inflammation of the mucous

membrane are found in all the parenchyma, and are the consequence of the irritating principle, the cantharides, carried into all the organs by the circulation. If a blister be left on sufficiently long the same lesions are obtained. M. Cornil therefore thinks that large blisters applied to the chest and left on from fifteen to twenty hours are more injurious than useful. Not only are systitis and nephritis brought on, but inflammation of the bronchi and of the pulmonary parenchyma itself. He has thus arrived at the conclusion that in order that blisters should not be injurious they should not be allowed to remain on more than from three to four hours. Only a few weeks ago I met with a case exactly illustrating this very point. A little girl of three years old was brought to me suffering from slight hematuria, the urine being, however, only very faintly tinged with pink. There was a constant dribbling of urine which sopped the child's clothes. She was extremely restless, had lost flesh, and appeared to be rapidly getting into an extremely low condition. About three weeks before she had been ordered to have a piece of plaster (*Emplastrum calefaciens*, B. P.) applied over the chest, as she was suffering from slight chronic bronchitis. The medical man who was attending her and had ordered it had neglected to see that it was removed after a day or so, and these symptoms of incipient cantharides poisoning were the result. The removal of the plaster was followed by the immediate cessation of the hematuria and in three days the child was perfectly well. My own feeling is that the actual cautery is much neglected here in England. A single application of it is often sufficient to do thoroughly what constant applications of cantharides will not effect, and though the name of the instrument is calculated to inspire alarm, the feeling is quite groundless. Of its effect in cases of chronic synovitis I can not speak too highly.

As the time of meeting approaches the evidence of general interest in the International Medical Congress becomes increasingly apparent. In several of the sections the number of communications already promised is large enough to fill up the entire time likely to be at their disposal, and these are by

contributors whose high scientific character is sufficient guarantee for the merit of their intended papers. The choice of the Executive Committee of a representative of French medical science to give the fourth of the general addresses has fallen upon Dr. Maurice Raynard, a distinguished physician and an accomplished orator, the author of *Le Medecin au Temps de Molière*, as well as more strictly scientific works of high merit. In Paris a lively interest is taken in all that pertains to the Congress by a large number of the hospital physicians and surgeons, and a number of medical men from the provincial French towns and schools have signified their intention to be present. Cordial notices continue to appear in the foreign medical journals, and a highly complimentary one in the *Berliner Medicinische Wochenschrift* is particularly worthy of notice. The editor, Dr. Waldenburg, says that the Executive Committee are making the most strenuous efforts to render the meeting by far the most comprehensive and magnificent medical congress held up to this time, and to obviate the objections which are often and justly to be made against international meetings. He especially points out the comprehensive and practical nature of the programme which he thinks should give the most general satisfaction. The Empress of Germany herself, who, as is well known, lends the weight of her high position as well as her own personal activity to all projects for the alleviation of the sufferings of the sick and wounded, whether in peace or in war, has sent a letter in which she expresses her lively interest in the Congress, and her intention to delegate the distinguished director of the Augusta Hospital in Berlin (her special charge), Professor Keister, to represent her at the Congress. The College of Surgeons have decided to give a *conversazione* in the Hunterian Museum on Friday, August 5, and the preparations that are being made both in respect to public and to private hospitality will not be unworthy of so great an occasion.

Reviews.

A Treatise on Bright's Disease and Diabetes, WITH SPECIAL REFERENCE TO PATHOLOGY AND THERAPEUTICS. By JAMES TYSON, A.M., M.D., Professor of General Pathology and Morbid Anatomy in the University of Pennsylvania. With illustrations. Philadelphia: Lindsay & Blakiston. 1881. 8vo. Pp. 312.

Dr. Tyson in his preface thinks an apology may be necessary for having written the above book; but when one takes into consideration the fact that the author's studies and practical work have all been devoted to this special branch of medicine for the past fifteen years, it will appear that an apology is superfluous. In this work there are many things that are in his valuable little book, "Practical Examination of the Urine," and a great many things that are not. Two hundred and nineteen pages, divided into eleven sections, are devoted to Bright's disease. Probably the most important section is the first, in which is given a most lucid description of the structure of the kidney. Section 2 gives the tests for albumen, the ordinary and extraordinary tests; section 3 treats of tube-casts and their clinical significance; section 4 is a short chapter on the classification of Bright's disease; and sections 5, 6, 7, and 8 treat of the etiology, morbid anatomy, symptoms, complications, diagnosis, prognosis, and treatment of the several forms of nephritis. Section 9 is on retinitis in Bright's disease, by Wm. F. Norris, M.D., Clinical Professor of Ophthalmology in the University of Pennsylvania. Section 10, on suppurative interstitial nephritis, and section 11, on passive congestion of the kidney, close the subject of Bright's disease. The remaining eighty-three pages are devoted to diabetes mellitus and diabetes insipidus. In regard to that vexed question, the pathology of diabetes mellitus, Dr. Tyson gives the opinions of the highest authorities, and then admits that the collection of facts upon the subject is somewhat chaotic. He

believes, however, that injuries to the nervous system, especially in the medulla oblongata, and tumors in the same region, may cause an active hyperemia of the liver which results in glycosuria. Again, glycosuria is caused by malassimilation dependent upon derangement of the digestive organs, which include the liver. The treatment is dietetic, hygienic, and medicinal. The first drug the author uses is ergot, because he has been able to trace to it results more directly than to any other remedy. Opium, iodide and bromide of potassium, and strychnia are also recommended; but with the wisest treatment it must be admitted that rarely do cases recover.

The book has a convenient index, is well printed, and merits a place on the shelf of the progressive physician. A. M.

The Hygiene and Treatment of Catarrh. Part I. Hygiene and Sanative Measures. Part II. Therapeutic Measures. With forty illustrations. By THOMAS F. RUMBOLD, M.D. St. Louis: Geo. O. Rumbold & Co. 1881. 12mo. Pp. 473.

Part I of this book was issued as a separate book a few months since and reviewed in the May number of the AMERICAN PRACTITIONER.

In regard to therapeutic measures, a *sine qua non* is, first, cleansing of the passages; and for this purpose the spray-producer is of most utility. To the spray-producer Dr. R. attaches tubes of his own invention, of different lengths and angles, so as to throw the cleansing and medicated spray to every part of the nares, pharynx, and larynx. One of the most useful instruments devised by the author is the hinged pharyngeal mirror, by pressure upon the handle of which the mirror can be rotated or any desired inclination given. Among the rare symptoms of nasal and pharyngo-nasal catarrh are mentioned pain in the top of the head, pain and numbness in arms, the fingers, and the back of the neck, dyspepsia, and palpitation

of the heart. When there is considerable discharge from the nasal passages they are cleansed by the spray-producer with the following solution:

R Carabolic acid,	gr. j;
Glycerin,	$\frac{5}{3}$ ij;
Water,	$\frac{5}{3}$ ij.

After the passages are *clean*, a small quantity of vaseline is melted in the bowl of the spray-producer, and two to five drops of the *pinus canadensis* mixture added. The mixture consists of

R Pinus canadensis,	gr. xv;
Glycerinae,	$\frac{5}{3}$ ss;
Acidi carbol.,	gr. ss;
Aqua ferr.,	$\frac{5}{3}$ jss.
Ft. sol.	

This is applied by the spray to every part. With respect to elongation of the uvula, the writer doubts if it is ever the cause of a tickling cough, and so questions the propriety of excision of the uvula. The last fifty-six pages are devoted to reports of cases. It is remarkable that Dr. Rumbold recommends scarcely any remedy as a local application except the *pinus canadensis* mixture. In part first it is stated that a bath once in one or two weeks in summer and once in four to eight weeks in winter is often enough. The author must have been reading John Hay's *Castilian Days* when he wrote this, in which book it is stated that in Spain it used to be taught that water was never to be applied externally except in baptism, and further states that at a great social gathering the richest, most accomplished, and beautiful señoritas would have streaks of dirt encircling their necks.

There is much in the book that is worth remembering, the first part being of the popular style. The presswork and binding are very inferior, and capitals incorrectly used often mar the appearance of the pages.

A. M.

Clinic of the Month.

ACUTE PRIMARY SYNOVITIS OF THE HIP.—Dr. V. P. Gibney, of the Hospital for the Ruptured and Crippled, reports (New York Medical Journal) the following cases, to call the attention of those who are in general practice to a disease which he believes must occur with more frequency than we should naturally suppose. There are cases of so-called hip-disease, running a comparatively brief course and occurring in children from eight or ten to fifteen years of age, the history of which would indicate that nothing more than the synovial membrane was ever the seat of lesion. The patients between the ages of two and seven years who come under our observation for joint-disease as a rule have a primary lesion in the bone—a chronic central osteitis of the epiphysis—and the synovial membrane is not involved until a late period in the disease.

The history of an osteitis is different from that of a synovitis. In the one we have an almost imperceptible beginning; in the other the invasion is acute and well defined. The signs on examination too differ materially. In the early stages of an osteitis we get no joint-tenderness, and the pain is not acute enough to prevent the child from walking. In synovitis the joint-tenderness is very marked, and the patient after the first twenty-four hours is unable to walk during the first and second weeks. The one disease is, as a rule, chronic; the other is acute. One extends over a period varying from two to five years; the other over a period varying from four to ten weeks.

It is difficult to formulate symptoms—symptoms that are pathognomonic. One must examine the case with care, testing the functions and sensitiveness of the joint thoroughly, employing such means as may suggest themselves. He must remember that if the joint be tender he should get referred pain in the obturator whenever the joint surfaces are approximated. There

should be no infiltration in the periarticular tissues. Sometimes one can perceive an elastic fullness about the trochanter or below the groin, if there be much distension of the capsular ligament. Then there must be a history of acute pain and great tenderness. The history will be very clear, the mother being able to name the day and the hour frequently when the first attack of pain was experienced. A diagnosis can often be reached by exclusion.

As to prognosis, he does not know of any cases that have not made a good recovery. The function of the joint is restored, and no one can tell from the gait that any joint-lesion has ever existed.

The treatment has been very simple; namely, *rest* and *counter-irritation*.

CASE I. Maggie M., aged nine. The hygienic surroundings had been poor, yet the child had been in good health up to the invasion of the present disease, the first symptoms of which appeared on the morning of September 12, 1879, without any assignable cause, unless perhaps exposure to cold may be regarded as a cause. The girl walked a little lame that morning, favoring the left side, and referring the pain to the knee; was not very lame, and indeed rested very well that night; but the next morning, the 13th, she was unable to walk at all, so tender the joint and so acute the pain. In the afternoon fever came on and persisted throughout the entire night. She suffered very much every day and every night until the day of her admission, September 19th. While asleep the limb was flexed at the hip and at the knee. The pain had been paroxysmal, and had been referred always to the groin, the inner side of the thigh, and the knee. The appetite had been good and the bowels regular. Considerable difficulty was experienced in preparing her for examination.

While the patient was quite anemic, the muscular system was fairly developed. As she stood, the right limb bore the weight, while the left was slightly flexed at the knee, the foot being everted. She was able to walk a short distance in the room, yet the lameness was very marked. Firm pressure over the trochanter in the line of the axis of the neck of the bone caused acute pain, which was referred to the inner side of the thigh and knee. Percussion of the flexed knee in the axis of the femur did not produce pain. There was no tenderness on firm pressure in the groin or in the iliac region or in the ilio-costal

space. There was no infiltration or swelling in any of the localities just enumerated. The nates on the left side was broadened, though there was no infiltration here. The superficial inguinal glands were slightly enlarged on both sides. The thigh could not be extended beyond 150° without tilting the pelvis; it could be flexed to 90° , though she complained of pain in the groin when it was forced beyond this angle. Abduction and adduction could be made over one half the normal arcs. Pulse 160; rectal temperature 101.5° F. A blister was applied over the gluteal region the night of her admission, and cod-liver oil and iron mixtures were administered.

September 28th. Most decided relief since admission. She is now free from pain, and walks quite easily, only a slight halt being perceptible. No tenderness in or about the joint. Another blister was applied on the evening of the 30th, and on October 17th it was recorded that she had grown comparatively stout and walked without an appreciable limp. The only change observed in the nates was, that the supra-trochanteric dimple was a little shallower than that on the right side. The limbs were equal in size, and movements at the joint were perfect and painless. Pressure over the trochanter in the direction of the joint gave no pain; concussion gave none. The cure was complete.

October 24th. Submitted to a thorough examination, and the supra-trochanteric dimple found normal. No sign or symptom of disease. Discharged this date, the parents promising to report on the first sign of any relapse. At the present writing—March 1, 1881—she has not returned.

CASE II. K., aged twelve years, admitted to hospital October 3, 1879, was a well-developed, muscular-looking lad. There was a history of phthisis on both sides of the family, and the father was reported to be suffering at the time from sciatica. Had been in excellent health until one month before, when he was seized with pain on the inner side of his right thigh. He had been in bathing quite frequently during the latter part of the summer—three or four times a day—and it was to exposure or fatigue that his pain was attributed. He was able to walk around the first day, although he was decidedly lame. On the third day he took to bed, so tender had the parts in and about the hip become. There was considerable febrile disturbance, without constipation, and morphia had to be administered every night to allay the pain. The hip and the knee alternately had been the seat of pain, and the limb had been with difficulty moved at all. Recently he had suffered most in the distribution of that branch of the obturator which supplies the knee. He held the thigh acutely flexed while lying in bed. He was taken from his bed this morning and brought into the hospital.

Is able to stand, although the weight is borne on the left limb, while the right is a little advanced, the foot being everted. He remarks that this is the first time he has been able to set his foot squarely on the floor since the beginning of his illness. As he attempts to turn he does so by means of the left foot. Can walk only when well supported on each side. His face is indicative of great suffering. The thorax and spinal column are examined with negative results. There is much width to the nates on the right side; the fold is obliterated. No tenderness over sacro-iliac junction, and none elicited on crowding the alæ of the pelvis together. No infiltration in the groin or in the nates; no tenderness here on handling the parts. The superficial inguinal glands are a little enlarged. Light pressure in the groin or over the trochanter gives rise to no pain; no pain on pressure along the shaft of the femur. If firm pressure be made over the trochanter in the line of the neck of the bone he winces quite markedly, and refers the pain to the outer aspect of the thigh and about the knee. Concussion of the joint gives rise to much pain. No dullness or tenderness in either the iliac fossa or the ilio-costal space. The limbs are equal in size, with the exception of their upper thirds, where the right one is one inch larger than the left. This may be due to the influence of two fly-blisters on the inner side of the thigh, cicatrices of which now remain. These were applied by order of the physician at his home. He can not be induced to flex the thigh beyond 135° , nor will he permit extension beyond 160° . Abduction, adduction, and rotation are quite impossible, so marked is the reflex muscular action when these movements are attempted. The rectal temperature is 102.5° . Diagnosis, acute synovitis of the hip. Large fly-blister is applied over the trochanteric region.

October 5th, two days after admission, he is walking without support, and the improvement is at least fifty per cent. The blistered surface is being poulticed every six hours.

October 15th. This surface has healed, and the contour of the nates is nearly restored. He walks with much facility, limping very little. No joint-tenderness can be elicited. Deemed expedient, however, to follow up the blistering, and another is applied this evening in the same region.

November 3. Last blistered surface has been a long time healing; many superficial ulcers remain at site of blister. For the past few days he has been walking with a mere trace of a limp; had no pain until last night, when by accident another patient ran against him, striking the gluteal region with the wheel of a rolling chair with considerable force; consequently he is very lame this morning, and the

soft parts, the inguinal glands especially, are infiltrated to a great extent. No joint-tenderness can be found, however, by the different tests, and the pain and tenderness are thus proved to be periarticular. It would seem then that the contusion has simply aggravated the periarthritic infiltration resulting from the second vesication, without injuring the joint. He is put to bed for a few days and the poultices are renewed.

December 13th. The ulcers have been most obstinate, and the periarthritis of our own making has given him much more trouble than did the synovitis after his admission to the hospital. They (the ulcers) have finally a scab over each. A few days ago the boy was submitted to a thorough examination regarding joint-functions, and these were found perfectly restored.

January 12, 1880. Discharged cured. General health excellent.

October 31st. The father writes, in response to a letter of inquiry, that there has been no sign of any relapse, and that the boy is still free from pain and lameness.

THE VALUE OF PAIN AS A SYMPTOM OF EAR-DISEASE.—Mr. Field, the very excellent aural surgeon to St. Mary's Hospital, London, reports a series of cases of disease of the ear accompanied by pain, and remarks as follows :

Cases of ear-disease may be conveniently divided for clinical purposes into two great groups, namely, those of persons who seek advice for pain in or about the ear (as well as for discharge from the ear without pain), and of persons who complain of loss of hearing, including those with tinnitus and vertigo. In the present paper it is with the first group that we are more particularly concerned.

Those cases having pain for their prominent symptom may be divided for practical purposes into two classes : first, those in which the disease is in the outer ear, or external meatus, and is due to the presence of foreign bodies, as wax, or to otitis externa, either of a phlegmonous or dermoid nature ; and secondly, those in which the disease is in the middle ear, and may be either of a catarrhal or of a more serious type. The first class of cases may be generally recognized with tolerable ease by a superficial examination or by use of the speculum. With an account of these I need not trouble my readers further than to say that in all instances of pain in or about the ear it is most necessary that a correct answer be given to the question whether the pain arises from an affection of the meatus. This answer must not

be based upon a mere guess or supposition ; it can and must be established by accurate and satisfactory observation ; and upon this the life of the patient may depend. A decision having been satisfactorily arrived at if the disease be located in the middle ear, it now remains to consider its nature ; and this brings me to the more especial subject of the present paper. Speaking roughly, the second class of cases may again be divided into three groups : first, those in which there is pain, more or less severe, but without much constitutional disturbance ; secondly, those in which the pain is associated with other and graver symptoms ; thirdly, perhaps I should add, cases in which there is no complaint of pain but in which a discharge exists. In the first group the inflammation of the middle ear is merely catarrhal ; the pain is unaccompanied by any marked rise of temperature and is not of an intense and throbbing character ; there is neither vomiting nor convulsions nor any external swelling about the ear or mastoid process. Such cases as these depend generally upon cold or a disordered stomach, and sometimes upon gout or other constitutional affections. Their treatment is simple and the prognosis good, for they very commonly do not pass on to suppuration. The second group of cases is much more serious. The constitutional symptoms are very severe ; intense throbbing pain in the ear is accompanied and often disguised by the headache of inflammatory fever, hence the nature of the disease may be overlooked. With these symptoms there may be vomiting, high fever, delirium, and even convulsions. The pulse may be frequent or slow and deliberate, having the character of the "cerebral pulse;" in fact the attack may very closely simulate meningitis, a disease in which it is not unlikely to terminate. In these cases we have to deal with an inflammation, not of the mucous membrane only, but also of the connective tissues of the periosteum, and hence often of the bone itself. The thin walls of the cavity separate it above from the brain and its membranes, below from the jugular vein, and behind from the mastoid cells ; in front it has an outlet by the eustachian tube ; on its inner wall is the delicate internal ear, and on its outer the tympanic membrane. The result will therefore depend on the side suffering most from the attack ; thus it may terminate in meningitis, or cerebral abscess, in phlebitis and pyemia, in disease of the mastoid cells, in resolution through the eustachian tube, in total destruction of the organ of hearing by attacking the internal ear, or by temporary or permanent interference with hearing, consequent on injury to the tympanic membrane. To combat the disease our treatment must be correspondingly active ; sharp antiphlogistic remedies and leeching as free as the cases indicate will be always necessary, while the surgeon must be ready to

cut deeply down upon the mastoid process should there be edema there, or to puncture the membrane if it is found bulging.

The cases I have narrated are nearly all examples of otitis interna, and such cases are very liable to simulate cerebral disease where it does not really exist, and if left to themselves they are very liable to produce it. All the symptoms of meningitis may be present in a case of otitis interna and that yet the case may recover. Similar symptoms with a like result arise occasionally from suppuration in the eyeball or orbital cavity. Whether in these cases meningitis really occurs and subsides, or whether symptoms of meningeal inflammation are produced by mere hyperemia, it is difficult to determine; the knowledge of their existence should make our prognosis guarded when we suspect meningitis from ear-disease. Such cases are on the one hand hopeful, because by treating the ear-disease we may be able to cure the patient; but on the other hand they may be most grave, for intracranial mischief may have arisen against which we shall be powerless. There can be no doubt, as I have already remarked, that many cases of obscure cerebral symptoms in children, some of which end in meningitis, are due to otitis interna. In all those cases commonly grouped under cerebral irritation or suspected meningitis, the ear should be examined with a speculum, the use of which should be as much a matter of routine as that of the ophthalmoscope. Should the membrane be found bulging it will probably require incision; but this operation of course must not be rashly undertaken since it requires both experience and skill.

The other treatment necessary should disease of the ear be detected has already been described. It is certain that the lives of many children might be saved were the practice more generally followed; for not a few die annually from acute otitis interna and its immediate results. The treatment of the chronic discharge from the ear which follows this disease in most children who survive it would prevent those most painful cases of suppurative meningitis, cerebral abscess, and pyemia so common in adults—the miserable results of neglected ear-disease in childhood. The want of familiarity with the ear-speculum shown by many medical men is remarkable, especially when we consider that cases of tinnitus, neuralgia, headache, vertigo, epilepsy, cerebral irritation, brain-disease, and pyemia, due to ear-disease, frequently come under their observation. Unfortunately a large proportion of these affections pass unrecognized.

Pain which has its origin in the ear is by no means localized in that organ. It may be either in front, above, behind, or below it; indeed any where on the same side of the head and perhaps on each.

The reason for this is easily discovered. The external, middle, and internal ear have all very far-reaching nerve connections. Thus in front of and above the external ear are ramifications of the auriculo-temporal branch of the third division of the fifth; behind, above, and below are the small occipital and great auricular branches of the cervical plexus; immediately behind the pinna the auricular branch of the pneumogastric comes to the surface and gives rise to very important communications; all these nerves anastomose in and around the pinna. In the tympanic cavity we find an equally wide-reaching plexus whose connections are as follows: the tympanic branch (Jacobson's nerve) from the petrous ganglion of the glosso-pharyngeal communicates with the great superficial petrosal which passes to the spheno-palatine ganglion; its small superficial petrosal twig goes to the otic ganglion; and a third filament passes to the carotid plexus of the sympathetic. All these nerves are united in the tympanic plexus, and pain produced in the tympanum may radiate over the wide area which they occupy.

NASAL POLYPS.—Dr. W. H. Daly, of Pittsburgh, concludes in the Archives of Laryngology for April, a valuable paper on this subject, with the following:

In operations for the removal of polyps, or the reduction of growths in the retro-nasal region, either by means of the loop, forceps, or galvano cautery, the tip of the index finger should be held in the vault of the pharynx as a guide. With it there, the operator can adjust the loop, or guide the forceps, and engage the growth within their grasp. He can also place the point of the cautery electrode wherever he wishes it, then, withdrawing the finger into the lower pharynx, out of danger of being burned, close the current as long as it is safe at a time, which should always be brief, with longer intervals to allow cooling.

Then inspect again the parts, and renew the burning, if necessary, until sufficient destruction of the growths or their pedicles has been accomplished.

The operator should employ the index finger of his *left* hand as guide in the *left* side of the patient's pharyngeal vault, instructing the patient to lean a little forward and press against the operator's finger. By this means the patient's head is held firm, and sufficient force can be used to overcome the expulsive action of the levator palati muscles, which soon give way, and the tip of the finger is brought directly to the pharyngeal orifices of the posterior nares, while with the right

hand the loop-handle, the forceps, or the electrode can be guided with certainty into any of the fossæ of the nasal cavity.

In operating in the patient's right naso-pharynx, the index finger of the operator's right hand should be used as the guide in the same manner as detailed above.

This plan gives many advantages in operating, as the index finger, in the retro-nasal opening is a certain guide and director, as well as an efficient protection to the eustachian orifices and septum nasi.

I dwell on these points because little is said in the books upon this plan of operating; a trial of it will convince the surgeon of its usefulness.

After removal of polyps the patient should be kept upon treatment, and the nares carefully inspected at intervals of three days at least, and the milder cleansing applications should be daily used by the patient himself. Any regrowths should be at once destroyed and their bases cauterized.

Any of the stronger purgative mineral waters, as the Carlsbad, Hunyadi Janos, or Ofner Rakoczy, are useful during this treatment to allay tendency to inflammatory febrile action.

Nothing less than a relief of the catarrhal condition of the nasal mucous membrane will insure immunity from a return of the growths, and the patient must receive proper medical and local treatment for this purpose.

NON-MORTAL FRACTURES OF THE BASE OF THE SKULL.—The base is the most fragile part of the cranial dome, being flatter, thinner, and more brittle, destitute, for the most part, of diploë, its sutures non-serrated, and perforated by foramina and fissures, it is by these anatomical and physical peculiarities much less able to withstand assaults from without than the vault, and fractures are therefore common. According to Dr. John A. Lidell, of New York, who contributes a paper upon this subject to the American Journal of the Medical Sciences for April, such fractures are less deadly than is generally considered by surgical writers. One hundred and thirty-seven cases are summarized in this valuable paper, from which it appears, first, that in the late war recovery took place in a large proportion of gunshot fractures involving the base of the skull, and secondly, that fractures in general involving the base of the skull prove mor-

tal much less frequently than has been generally supposed, such injuries are therefore not to be considered as necessarily fatal. In two cases reported by Dr. Lidell, carotid ligation was successfully resorted to for persistent hemorrhage from the middle meningeal artery. Those patients did best who were kept at rest and treated antiphlogistically by low diet, cold to head, purgatives, mercurials, and blisters. Several apparently desperate cases were saved in this way. The therapeutic deduction from this study of the importance of rest and antiphlogistic treatment during the inflammatory and suppurative periods is of great practical value.

A considerable number of the cases of recovery subsequently suffered from various forms of nerve-disorder, such as atrophy, contraction of tendons in paralyzed limbs, headache, vertigo, blindness and deafness, epilepsy, and impairment of the mental faculties, evidently connected with changes of a chronic degenerative character going on at the base of the brain. This ultimate result should not be lost sight of in the prognosis, and also calls for judicious treatment.

OÖPHORECTOMY FOR FIBROID TUMORS OF THE UTERUS.—Dr. G. H. Balleray, of Paterson, N. J., calls attention in the American Journal of the Medical Sciences for April to the necessity for oöphorectomy in cases of uterine fibroma attended by profuse hemorrhage before the patient is reduced to such a condition that the operation can only be undertaken as a forlorn hope; the difficulties of the operation should not be ignored, but, on the contrary, a full knowledge of them by the surgeon and an appreciation of the possible dangers by the patient are equally essential in either event. That oöphorectomy is destined to be the operation of the future in cases of bleeding fibroid of the uterus, which has resisted all other treatment, which is not susceptible of removal through the vagina, and in which it is evident that unless the hemorrhage is arrested the patient must inevitably perish, can hardly admit of a doubt. The cessation of activity of such growths after the menopause

is a subject of common knowledge, and the premature induction of the menopause by the removal of the ovaries in some cases holds out the only prospect of recovery. The rule should be, if without an operation the patient *must* die, and if an operation holds out any hope of success, however slight, and if the patient, understanding the facts of the case, elect the operation, it is the duty of the surgeon to perform it.

NON-MALIGNANT ULCERATION OF THE RECTUM AND ANUS.—
Dr. Charles B. Kelsey, Surgeon to the Infirmary for Diseases of the Rectum, New York, contributes a paper upon the different forms of non-malignant ulcerative disease of the ano-rectal region, classifying the ulcers according to their etiology into simple, tubercular, scrofulous, dysenteric, venereal, those due to stricture, and those due to the gangrene following the severe fevers. The importance of a thorough examination with a duck-bill speculum under ether is so obvious that it is a matter of surprise that this manipulation, furnishing the only means of exact diagnosis, is so commonly neglected by physicians. In the majority of cases the existence of an ulcer being ascertained, provided that syphilis be excluded, the ulcers in the rectum proper will belong to the first or simple variety of the disease, and will yield to local applications of bismuth, iodoform, or solution of nitrate of silver. He lays particular stress upon the absolute necessity of perfect rest and fluid diet, without which, he says, no treatment will be of much avail. To them, however, he adds other remedies in the way of general medication and local applications. (*Ibid.*)

Notes and Queries.

THE AMERICAN MEDICAL ASSOCIATION.—The Association met in its thirty-second annual session at 11 o'clock A.M. in Richmond, Va., Tuesday, May 3, 1881. We have only space for a portion of the more practical part of the work of the Association. The following condensed extracts from the proceedings will be read with interest by all practitioners:

Dr. John T. Hodgen, of St. Louis, the president of the Association, delivered the annual address. He divided surgeons into those seeking to perform every practicable operation and the other avoiding operations whenever it is possible. The former include the bold, the enterprising, the ambitious, and the reckless of our profession; the other the timid, the conservative, the cautious, and the procrastinating. The former class is largely made up of young men, enthusiastic and full of inspiration, caught from professors whose task is to make the way clear and easy—students of the current medical literature, which teems with new suggestions and is crowded with reports of remarkable cases and wonderful operations, generally ending or reported as ending happily to the patient and to the great credit of the reporter. Simon excises a kidney, turns an aberrant ureter into the rectum, touches through the natural passages a stone in the kidney, and immediately hundreds of ambitious surgeons are seeking kidneys to excise, ureters to turn, and renal calculi to touch. Battey removes an ovary for the relief of an obscure nervous disorder, and forthwith ovaries are removed for almost every imaginable nervous disorder. Billroth cuts out a cancerous larynx or a diseased pylorus, and at once a demand springs up for similar cases, and the daring operations are repeated in all the four quarters of the globe. The second class is recruited largely from the first, and often only after many lessons of bitter disappointment drawn from the experience of many and grave disasters.

The practice of seeking cases for operation and of operating by blindly following the dicta of authority, without a full understanding of the condition to be relieved, is well illustrated by two surgical procedures which have been resorted to with far too great frequency, as

I believe, by gynecologists during the past and present decades. Of one of these procedures, the division of the cervix uteri for flexures—an operation without proper foundation in pathology, which was generally useless and often dangerous, and which always entailed deformity—Emmet holds the following energetic language: "Since the practice of indiscriminate division of the cervix was first introduced by Professor Simpson, more malpractice has been perpetrated throughout the world in the name of this simple operation than from any other procedure known to the profession." So, too, great wrong has been done in seeking to follow the lead of Dr. Emmet in the performance of operations for the cure of lacerations of the cervix uteri. From the large number of operations reported by many practitioners it may be fairly concluded that it has often been needlessly and unprofitably performed.

A simple knowledge, however accurate, of the parts involved does not qualify one to make an intelligent prognosis, to decide upon the advisability of an operation or treat judiciously even such diseases as consist mainly in pathological changes in the part in question, to say nothing of the many cases in which subjective symptoms are referred to a particular part when they are in fact but the local expression of some remote or possibly constitutional trouble. Herein lies a danger which threatens the profession, through the adoption of exclusive specialties by those not well trained in general medicine. It can not be denied that the early and exclusive study of the affections of a part tends to narrow the intellectual grasp and cramp the powers of the man who yields to the influences incident to such partial training. In the best sense, a specialist is a physician and something more; in the worst, he is something else and something less than a physician.

The rapid progress made of late years in the precision and perfection of regional surgery, the brilliant triumphs secured, and the almost unlimited possibilities attained, combined to tempt surgeons to reckless operative procedures. Captivated by the knowledge that almost every region of the body has been and therefore may be invaded without necessarily destroying life, we are in danger of overlooking the general influences which are ever present to modify and control the results of local injuries. The local conditions calling for surgical operations are besides more easily studied by the young surgeons than the general conditions which may forbid them, and are more fully discussed in the text-books and college lectures. To learn what to do and how to do it, is always more attractive to the student than to be told what not to do. And this is especially true if the thing not to be done is something which he believes he can do well.

On the other hand, we recognize certain diseases and conditions in which, however defective our knowledge may be in some respects, we are at least certain that very early operation is indicated, both as involving a minimum of risk and as offering the best or perhaps only chance of saving life or of averting great calamity. In this class we include tumors, benign or quasi-malignant. The propriety of the early removal of quasi-malignant tumors is nowhere better illustrated than in the case of sarcoma of the choroid—a disease which, by the aid of the ophthalmoscope, can now be positively and accurately diagnosticated at a very early stage of development. Left to itself for a few months, it will surely break through the outer coat of the eyeball, and soon develop into a fatal and hideous tumor of the orbit, complicated probably with sarcomatous deposits in distant parts. Removed at an early stage by enucleation of the eyeball, it may never return *in situ*, and life may be indefinitely prolonged.

In rodent cancer and in epithelioma we now expect a cure by excision, provided it is done early enough; and even in mammary scirrhus removal of the breast has exceptionally effected a permanent cure. Sympathetic ophthalmia affords a striking instance, which may result either from not recognizing a danger in season or from a want of promptness in dealing with it.

Scarcely any fact is better established than that a high condition of health is not the condition which best fits the patient to bear the forced confinement, the impaired digestion, the imperfect assimilation, and the perverted excretion which follow any serious bodily injury or grave surgical operation. In such patients we have learned to dread surgical fever and active inflammatory complications, leading possibly to septicemia, and ending, it may be, in death. So, too, that standard of health marked by an unusual ability to bear continuous mental strain, taxing the digestive and assimilative organs to their utmost, is not that under which the effects of shock are best borne, whether it be the shock of a severe injury or of a capital operation.

On the other hand, a man whose life is not marked by excessive tissue-change, whose digestive, assimilative, and excretory organs are not unduly taxed, and whose nervous system is not attuned to conditions of intense mental strain, is likely to bear well the shock of injury and the nutritive changes incident to prolonged confinement. Again, the chronic sufferer whose nutritive and excretory organs have become educated, so to speak, to make good the excessive waste incident to any continuous drain is often much better fitted to endure a grave surgical operation than is the new recruit of the army of sufferers. Very often the surgeon is compelled to act in the presence of morbid condi-

tions of the most complex character. Thus in strumous manifestations in connection with chronic suppurative disease of the joints and bones the profuse discharge makes the most exacting demands upon the nutritive functions, while the close confinement, pain, and loss of sleep combine to destroy the appetite and impair digestion and assimilation. In such a condition (so clearly set forth in the case of hip-disease by our distinguished ex-president, Dr. Sayre) we recognize in the cachexia the effect rather than the cause of the local trouble, and by resection or amputation of the offending limb we may arrest the exhausting discharge and restore the disturbed balances between the processes of nutrition and waste.

The dangers in certain depraved conditions of the body from injudiciously delaying an operation are forcibly depicted by Robert Barnes. He says, "My experience leads me to conclude that in cases of urgent disease there is more frequent occasion to regret having delayed the operation too long than having had recourse to it too soon. When through obstinate vomiting, for example, nutrition has long been arrested, the starved tissues, craving for supplies and falling into disintegration, feed the blood with depraved and noxious materials; the system feeds upon itself and poisons itself; the poisoned blood irritates the nervous centers, and these centers, wrought to a state of extreme morbid irritability, respond to the slightest peripheral uterine or emotional excitation. All nervous energy is thus diverted from its destination and exhausted in morbid action. Irritative fever ensues; the pulse rises to 140 or more; no organ of the body is capable of discharging its functions, for the pabulum of life is cut off at its very source. At this point, labor, whether it occurs spontaneously, as it often does, or be induced artificially, comes too late. The tissues are altered, the powers are impaired beyond recovery, and death soon follows."

Shock may act profoundly upon the whole economy. Arrested digestion, perverted assimilation, suspended secretion, and limited excretion may occur to vitiate the nutritive fluids of the body. Elements which should go to feed the tissues and provide materials for secretions remain unappropriated; excrementitious substances accumulate, and the body becomes gradually saturated with effete matters. Operations for the relief of patients with old and tight urethral strictures complicated with disease of the kidneys affords illustration of the serious consequences which may follow shock in an already diseased organism. Internal division or forced dilatation of such a structure may be attended with a degree of shock sufficient to arrest for the time the heart's action, or it may so act upon the whole nervous

system as to check secretion and excretion generally. The diseased kidneys may thus cease altogether to perform their functions, leading to speedy death from uremic poisoning; or, in the case of less aggravated renal trouble, the blood becoming surcharged with morbid material may no longer suffice to maintain the nervous centers in effective action; assimilation, secretion, and excretion may all fail, and death ensue from septicemia.

Anemia, resulting from sudden loss of blood, is particularly unfavorable to surgical interference. Besides the actual deficiency of blood, the diminished tension of the blood-vessels favors the absorption of septic products at the site of the injury; while the blood, diluted and vitiated by the additional fluids absorbed from the tissues, becomes loaded with effete organic matter, ready to take on putrefactive changes. A familiar instance of susceptibility to septic influences after a large hemorrhage will occur to every obstetrician who has learned how often metritis and septicemia follow excessive post-partum hemorrhage.

Besides want of space, another reason for the omission of reference to other conditions which may demand or forbid a resort to the knife is our want of exact knowledge. Especially is this true of those constitutional conditions we term diathesis. Using the word in its broadest sense, diathesis is any condition varying from the normal standard which disposes to the development of disease in the presence of trivial exciting causes. Other conditions which we habitually include under diathesis are themselves disease. Such, for instance, are scurvy, the scrofulous habit, tuberculosis, and syphilis. A diathesis may be transient or permanent, retrogressive or progressive. It may be so marked in its manifestations as to force its recognition upon even the most careless observer, or it may be so obscure as to elude the most painstaking scrutiny; and yet it may respond immediately and disastrously to an injury. In acknowledging our ignorance regarding the precise nature of such variations from the normal standard as we believe must exist in diseases like scurvy, scrofula, tuberculosis, etc., we recognize the existence of wide, uncultivated fields, rich, no doubt, in promise to future investigators. A more perfect animal chemistry, a more thorough histology, and a deeper research into the possibilities of pathological change will doubtless throw many a ray of light into regions where the darkness is now too dense for our vision to penetrate. To these fields coming generations of physicians will surely be attracted, in the faith that as man advances in knowledge and approaches somewhat nearer to the comprehen-

hension of the perfect wisdom which designed the wonderful physical organism, through which he is brought into relation with the world around him, he will be enabled to solve more and more of the difficult problems which now perplex and baffle us, and will gradually raise medicine to a position more nearly akin to that now accorded to the exacter sciences.

The Committee on Journalizing Transactions recommended the establishment of a weekly journal as the organ of the Association in the following resolution:

Resolved, That the president be authorized to appoint a committee of five to digest and report in detail, as soon as practicable, upon the time, place, and terms of the publication of such a journal, to elect an editor, fix his salary, and to arrange all other necessary details.

Adopted with so much of the resolution as related to the election of an editor struck out.

State Medicine.—Dr. J. L. Cabell read a paper on The National Board of Health and the International Sanitary Conference of 1881, which concluded as follows:

"There is therefore good reason for hoping that an international agreement may be arrived at between the States most frequently threatened with epidemic invasions. And, aside from this, the degree of attention which, as a result of the deliberations of the Conference, has been given to the subject of maritime sanitary police can not be without fruit in securing greater cleanliness, better ventilation of ships sailing on the high seas, and, in general, an improved sanitary condition of these important instruments of commerce, which become so often the carriers of the most deadly contagion from the failure to use such precautions as sanitary license suggests, and as it is hoped will now be enforced among the maritime powers of the world."

Dr. C. F. Folsom, of Boston, in a paper which he read on The Relation of the State to the Insane, spoke of the difference adopted at this time in the treatment of the insane and as to that which was formerly adopted. He also gave valuable statistical information as to the number of insane in various sections of the country. He argued in favor of the establishment of State lunacy boards. Among the points made were, first of all, that a lunacy board should embrace men with a thorough knowledge of insanity and its treatment. The chief duties of this board should be to secure proper care for the insane in private dwellings, where they are very liable to neglect. Secondly, they should require the commitment of lunatics to the asylum by necessary copies of the commitment papers, and otherwise looking into the cases, so as to be able to tell whether the lunatic

should be retained for care or be discharged. The paper was able, and full of valuable information.

Dr. Charles F. Stillman, of New York City, read a paper upon A New System of Surgical Mechanics, illustrated by numerous drawings and instruments. The system demonstrated by Dr. Stillman is based upon the principle of *local extension* as opposed to *general extension* developed by all other systems, which local extension is produced by the use of the sector splint in the various forms shown by him as adapted to the several joints. He first traced the history of this sector splint from the initial idea of two slatted and clamped strips, attached by copper plates, to its present improved and varied form. Having given a cursory mention of Buck's extension, various modifications of the long splints, Hutchinson's method, and Thomas's plan, of Liverpool, he summed up the advantages of his system as follows: 1. Extension at any angle with motion; 2. Extension at any angle with luxation; 3. Fixation; 4. Motion complete or limited, constant or occasional; 5. Exposure of surface about the joint, admitting compression, elastic or otherwise, hot and cold applications, blisters, dressings, and easy inspection. This was followed by an exhibition of splints for the spine, hip-joint, knee-joint, ankle-joint, and elbow. Also an instrument for reducing cases of talipes in various forms and of long standing, by which instrument the surfaces of the tarsal bones are separated before the foot is made to assume a normal position.

Dr. Kinlough, of South Carolina, thought too much advantage was claimed for such contrivances; thought much could be done by rest secured in other ways; wished this fact was better appreciated; was sorry he could not share the enthusiasm of Dr. Stillman, but had failed to secure as good results.

Dr. Quimby, of Jersey City, N. J., indorsed fully Dr. Kinlough's remarks, and was especially emphatic in approving the treatment of clubfoot with adhesive strips, plaster of Paris, etc., instead of costly shoes and braces; thought mechanical instruments were sometimes useful, but were also capable of great abuse, and thought that they did not control muscular contraction.

Dr. D. H. Goodwillie, of New York City, read a paper on Treatment of Arthritis of the Temporo-maxillary Articulation. He reported cases treated. Causes of arthritis are local and constitutional. Whenever it occurs, the motion of the jaws becomes impaired according to the cause, severity, and length of the disease, and often requires long treatment to restore the muscles to their normal condition. The treatment of the arthritis is done by means of an apparatus to relieve the joint of pressure on the inflamed articular surfaces. It is made as fol-

lows: An impression of the teeth of either jaw is taken and an interdental splint made, the posterior part of which is raised a little for the purpose of a fulcrum, on which the back tooth of the opposite jaw rests. Another impression is taken of the chin, and a rubber splint is made to fit it. A skull-cap is next made to fit the head closely, with elastic bands on each side passing down from it and fastened to the chin-splint. The interdental splint is placed in position in the mouth, and the back teeth of the jaw closed on the fulcrum of the interdental splint; then when pressure is made on the chin by tightening the elastic bands connecting the skull-cap with the chin-splint the joint is relieved from pressure.

Dr. Moore, of Rochester, called attention to cases where cicatricial bands caused the trouble, division of which usually cured them.

Dr. S. D. Gross, of Philadelphia, saw comparatively few such cases since the abuse of calomel has ceased; had not been able to accomplish much with wedges, etc.; alluded to section of the bone; had performed the operation.

Dr. Hunter McGuire, of Richmond, Va., said that one of the cases alluded to by Dr. Goodwillie afterward fell into his hands, and he was sorry to inform him that the case was not cured. There was no motion whatever. As every other plan had been tried by Drs. Sayre and Goodwillie, Dr. McGuire took out a wedge-shaped piece of bone just at the angle. The result was good. Also spoke of a case where a bridge of bone passed from upper to lower jaw for eleven years; no movements in joints; yet returned quickly after division of the bridge of bone. Thought with wedges, etc., the treatment should be prolonged.

Dr. Jacobi, in discussing Eczema, remarked that he supported Dr. White, of Boston, in controlling scratching by mechanical measures. He said that if scratching was prevented children would recover as easily as adults, and that although the procedure was somewhat severe still the mother and nurse would be saved a great deal of trouble. The mask for the head had proved very serviceable in his hands. As regards Dr. Bulkley's views, he thought that the constitutional causes were nothing more than what we have in any affection. Dr. Jacobi agrees with Hebra that no water should be used. Very rarely and in special cases the judicious use of water may be of service. The main point is to remove the scabs. For this purpose potassa soap, very soft, may be used, or liquor of caustic potassa with ten or twelve parts of olive or castor oil can be applied twice, three, four, or five times during the day, and will produce remedial effects very quickly. The surface left exudes the serum, which hardens and forms the scab. This

serum must be touched and taken up with a soft towel, and finally astringents are applied to the raw surface. These applications can be made to please the fancy of the physician. Zinc and diachylon plaster are both valuable. A number of cases will not be cured, and then we must resort to constitutional treatment. The milk of the nurse must be rendered digestible, and it will be found that many children will thrive better on artificial food than on the milk of the mother or nurse. A good general condition of the system must be obtained. To say that an eczema can be cured forever, is perhaps going too far, for we see cases repeatedly coming under our observation as cured. Just as in insane asylums we notice cases that are published several times as "cured," so it may be in eczema or any other intractable affection.

Dr. Jacobi, in the absence of Dr. R. J. Nunn, of Savannah, read a paper for him on the Treatment of Diphtheria. The causative influences are probably not the same in all cases. Medicines which cure the disease in Germany fail in this country; and the discussions as to the identity of croup, diphtheria, and scarlet fever are strong arguments in favor of this belief, and all treatment based upon one cause must fail to relieve all cases. A powder used by Dr. J. B. Read is as follows: Sulphur sub. grs. xlviij; acid tannic, grs. xij; acid salicylic, gr. j; pulv. potass. chlor. grs. xij. Precaution must be used in compounding this prescription. A little of this powder is put on the back of the tongue every hour or two, and a small piece of ice given afterward. It will be seen that this prescription is a combination of anti-septics principally. In another case treated by Dr. Nunn the following formula was used with good effect: Sulphur, grs. viij; acid boric, grs. iv; acid tannic, gr. j; acid salicylic, gr. j; resorcin, gr. j. Another formula is: Sulphur sub. gr. viij; acid boric, grs. iv; acid benzoic, gr. j; acid salicylic, gr. j; acid tannic, gr. j; acid tartaric, grs. iv; sodii chlorid. grs. iv; resorcin, gr. j. Dr. Nunn thinks that this formula will prove efficacious.

Dr. Lathrop, of New Hampshire, has experimented with chloroform largely, and finds it a highly useful agent. He uses it in diphtheria and other throat affections on a piece of cotton attached to a tube or penholder. The cases usually required visiting no longer than four days, but the cases were not so malignant as reported in other localities. He stated that no unpleasant effects have ever followed this plan of treatment, and that the child in true diphtheria would not complain of *smarting* from the application of chloroform. He had used this plan of treatment in one hundred cases. Constitutional measures are added.

Dr. William Lee, of Baltimore, has used equal parts of tinct. ferri chlorid. and ol. ricini with benefit. He considers the disease as local at first and then constitutional. A physician from his county had used large doses of ol. copaiba with benefit. An emetic was then given to remove the membrane.

Dr. G. Vivian, of Minnesota, has used in severe epidemics alcohol as an inhalation, and has employed as much as a quart of alcohol a day. He has never seen any constitutional effects ensue.

Dr. J. McNeal, of Gettysburg, Pa., recommends the following: Potass. bromid. 3 j; potass. chlorat. 3 ij; acid carbolic, grs. xx; aq. Oj. Use in an inhaler. Locally—chloroform, 3 ij; lin. saponis, 3 j to 3 ij.

Dr. F. E. Hitchcock, of Rockland, Maine, uses equal parts of sulphurous acid and water in an atomizer. The proportions can be varied and the acid used as a gargle. Cold affusion externally.

Dr. Jacobi, in answer to an inquiry concerning the benefit of pilocarpin, said that his opinion of it was unfavorable. It was proposed as a specific by a Dr. Guttmann; and while on this subject he would state that this gentleman was not Dr. Guttmann of Berlin. The article on pilocarpin had struck him as nothing more than an advertising arrangement. In diphtheria there are two forms—one in which the deposit can be readily separated from the mucous surface beneath, and one in which the deposit is deeply imbedded in the lower structures. In the latter form Dr. Jacobi believes that pilocarpin does harm, and in one case he thinks that death was hastened by using this drug. Pilocarpin debilitates the heart's action by giving rise to nausea and vomiting. The milder cases of diphtheria recover, as a rule, if left alone, and in all cases of the disease he thinks the utility of pilocarpin is doubtful. The paper in which pilocarpin was recommended as a specific is not satisfactory as regards the description of the cases treated; and to say that this and that remedy is a specific is certainly not dignified. If the remedy be used at all, a fluid extract is the best preparation, as the muriate of pilocarpin is decomposed in the stomach.

Dr. Jacobi also, in answer to a question from Dr. Lee concerning the effect of lime, said that his opinion of this agent was not so high as that of many writers, but that he would speak more fully of both lime and pilocarpin in his article on this subject.

Dr. W. C. Dabney read a paper on Nature and Treatment of Pneumonia, with conclusions as follows: Two views are held as to the nature of pneumonia—one that it is a specific fever; the other that it is a local inflammation, of which the fever is symptomatic. Argu-

ments in favor of the first view: 1. The disease ordinarily commences with a chill; 2. The constitutional disturbance is often out of proportion to the local disease; 3. The disease usually runs a definite course, and is self-limited; 4. The disease occasionally occurs as an epidemic. Arguments in favor of second view: Traumatic pneumonia is precisely similar to the idiopathic form. The indications of treatment in the first stage are (1) to lessen the amount of blood in the lungs and to check as far as possible the extension of the inflammation; (2) to reduce the temperature; and (3) to relieve pain. To fulfill the first indication, blood-letting, diaphoretics, saline purgatives, and cardiac sedatives are to be employed. To fulfill the second indication, quinine is the most important agent. To relieve pain synapisms, wet and dry cups and opiates may be resorted to. In the second stage the indications are (1) to lessen the consistency of the fibrinous exudation, and (2) to prevent over-distension of the heart. To fulfill the first indication, alkalies, especially carbonate of ammonia, are to be employed. To fulfill the second, alcoholic stimulants are especially useful. Digitalis may be also used with advantage. If so much respiratory surface is involved as to interfere seriously with respiration, oxygen gas should be used. In the third stage, tonics, a nutritious diet, etc., are advisable.

Dr. Lester, of Missouri, had failed yet to hear the argument which convinced his mind that pneumonia was a zymotic disease. He thought also that blood-letting was applicable to a very limited number of cases.

Dr. N. S. Davis, of Chicago, had never been able to decide that pneumonia was zymotic, but believed it to be local. He rose to protest against the course of reasoning pursued by some members. Even assuming that pneumonia was a zymotic disease and ran a definite course, this was no reason why it might not be cut short; and the physician had no right to fold his hands and do nothing because of such reasoning.

Dr. Lynch, of Baltimore, approved of Dr. Davis's remarks, but thought that in the present state of our knowledge we were not justified in using any remedy about which we were uncertain in an attempt to cut it short. In reference to the use of alkalies in pneumonia, he believed them to be valuable, particularly carbonate of ammonia, in certain stages of the disease, but not in the initial or even second stage.

Dr. Octerlony said that it seemed to be settled by discussion that if pneumonia was a zymotic disease it could not be cut short, but if local it could. Pneumonia, he thought, was a self-limited disease. In regard to the zymotic character of the disease, he must confess his mind had not been convinced; thought it local; wished to call atten-

tion to the danger of death from heart-clot. He thought carbonate of ammonia useful in other stages besides the third.

Dr. Ball, of Ohio, thought the idea of pneumonia being a self-limiting disease, and founding treatment upon that idea, to be exceedingly erroneous, and calculated to do great harm. Thought the disease could be cut short, and called attention to the method of treatment by repeated emetics early in the disease, and claimed that it was valuable in aborting the disease.

Dr. McCaul, of Michigan, thought that in his section venesection was not admissible, and that cardiac sedatives must be used with extreme caution. Did not think the disease was purely zymotic, but thought there was a zymotic condition of blood which tended to produce it.

Dr. Whittaker, of Cincinnati, asked, If pneumonia was a local disease, what caused it? Certainly exposure did not. We had, he thought, no right to call it a local disease until we knew its etiology.

Dr. Chadwick, of Boston, chairman of Section on Obstetrics and Gynecology, closes an able paper with the following general conclusions:

"The above quantitative analysis of obstetric and gynecological literature with regard to nationalities manifests the prominence of America in this branch of medicine. America contributes more journal articles than any other nation; supports by contributions, both literary and pecuniary, as many special periodicals as France, and twice as many as either England or Germany, and carries on as many special societies as all the other countries of the world together. England, despite the labors of Wells, Keith, Thornton, Barnes, Duncan, Tait, Leishman, and Playfair, is fast losing its preëminence in this branch of medicine, and has recently demonstrated its inability to support even one special journal by the discontinuance of the *Obstetric Journal of Great Britain and Ireland* on January 1st of the present year. France is exhibiting an unnatural activity under special influences already adduced. Germany holds on the even tenor of its way, while Belgium, Italy, Spain, Denmark, and Russia are awakening to a more active participation in the advance and dissemination of obstetric and gynecological lore.

"I have throughout these pages restricted myself to a quantitative study of the literature. I can not close without giving in a few words an estimate of the quality of each nation's contributions to the science and practice of gynecology and obstetrics. Germany unquestionably advances pure science more than any other nation; the papers in its three journals are the most profound and the most critical. France

manifests a great dearth of original ideas and a most discursive style of discussion, but considerable painstaking historical research; its journals are prolix, and, for the most part, profitless reading, and exceed in number the legitimate demand. England exhibits a waning interest in this branch of medicine, little originality, but a notable discrimination in adopting new theories and applying them to practice; its only special journal died a natural death at the close of the last year. To America I have no hesitation in according preëminence in this special field. Our countrymen meet the emergencies incident to child-bearing with a quickness of perception and readiness of action rarely seen in other countries. Their ingenuity has led them to devise new operations in gynecology and to carry their art with brilliant results, so that today the practice of that branch has reached a stage here far in advance of other nations. Of course our natural aptitudes lead many of us to overestimate the beneficial results of surgery; but, taken all in all, close observation and study in most of the countries of Europe has confirmed me in the opinion that in obstetrics and gynecology America leads the world. The two most prominent exponents of our branch in America, *The American Journal of Obstetrics* and the *Transactions of the American Gynecological Society*, present a more happy blending of scientific facts and practical suggestions than is found in any other special gynecological or obstetrical journals in the world."

Operative Interference in Gunshot Wounds of the Peritoneum was the title of a paper read by Dr. Hunter McGuire, of Richmond, chairman of the Section on Surgery. Few surgeons have had greater experience in treating gunshot wounds occurring both in military and civil life, and few have appreciated more fully how unsatisfactory are the results obtained from the expectant or do-nothing plan so much in vogue. The title of the paper indicates the grounds taken by the writer in favor of operative interference, and the views embodied in the paper tend to prove the position advanced by the writer that the patient will exchange an almost certain prospect of death for at least a good chance of recovery, and should, we think, embolden surgeons to think less of expectant treatment and more of operative interference. Statistics from the Crimean, the French, and the late civil war in America show that more than nine out of every ten cases of wounds of the belly opening into the cavity of the peritoneum perish, no other gunshot wounds being so deadly, not even penetrating and perforating wounds of the skull. In incised, punctured, and gunshot wounds of the peritoneum the general plan of treatment has been to enjoin absolute rest, give opium to prevent peristaltic action, and encourage the

formation of adhesions, in the idle hope of preventing extravasation into the peritoneal cavity. It is claimed that the wound may paralyze the muscular coat of the bowel, or in small wounds the mucous coat is everted and closes the aperture, or the part injured may not be covered with peritoneum and no extravasation take place within the peritoneal cavity, or that the serous membrane covering the intestine near the point wounded may become adherent to the omentum, to the bowel, or to the abdominal wall, and the orifice in the bowel become permanently closed; and last, but very rarely, the extravasated mass may become encysted, end in abscess, and discharge itself through the neighboring skin or mucous surface. In the opinion of the writer, when we remember that the alimentary canal is never completely empty, common sense teaches us that when an opening is made in any portion of the peritoneal cavity its contents will escape; that there will probably be less resistance to the passage of fecal matter through the unnatural aperture than along the sides of the canal itself. Gas may first be expelled, separating peritoneal surfaces, and then the fluid or solid contents of the bowel follow. Only one or two exceptions to this rule are reported in the history of the late war between the North and South. But besides alimentary effusion, blood, air, bile, and urine may also be extravasated into the peritoneal cavity. Penetrating wounds of the belly, with fecal effusion, are rapidly followed by general acute peritonitis. Ninety per cent die, and within forty-eight hours. Does peritonitis from any other cause, as a rule, kill as quickly? In spite of the assertion of Malgaigne and others that the organs contained in the belly fill the cavity to such repletion that shot-wounds of that space without visceral injury are impossible, post-mortem examinations and experiments upon dead bodies show that wounds of the peritoneum can be made without injury to the contained viscera. It has fallen to the lot of the writer to witness four such cases. Two occurring in civil life, and being the subjects of legal investigation, careful autopsies were made. Two were soldiers dying from peritonitis, and the autopsies showed no visceral lesion. These four cases, coming under the observation of one individual, and having their exact character shown by post-mortem examinations, prove that such results are not impossible and probably not as rare as we have been led to suppose. Those rare cases of recovery from penetrating wounds of the abdomen have induced surgeons to continue the expectant plan of treatment in place of what appears at first sight to be a desperate surgical interference. Some of the alleged recoveries may have been wounds of a portion of the large intestine not covered by peritoneum. Recovery, with fecal fistula, is not uncommon in this case; others may

have been penetrating wounds without visceral injury; others again may have been parietal wounds without peritoneal penetration. In connection with the four cases of gunshot wounds of the peritoneum alluded to by the writer, and in which there was no visceral injury, the total absence of shock was remarkable, and no diminution of temperature. One of them (a soldier) assured the writer that he did not know that he had been wounded until some time after he had been shot. Another (wounded in a duel) insisted that he was able to stand up and give his antagonist another fire. On the other hand, in all cases with visceral lesions the shock of injury is a prominent symptom. The presence or absence of shock seems to be a diagnostic point of no little value. If to this be added sudden meteorism, the character, extent, and direction of the wound, bloody discharges from the bowels or stomach, an almost certain diagnosis by rational symptoms will be reached. In reply to the question, why are these injuries so fatal? why, after escaping death from peritonitis, shock, and hemorrhage, peritonitis is fatal in forty-eight hours? the writer attributes death to some kind of blood-poisoning connected with peritonitis, just as we often see septicemia associated with peritonitis under other circumstances, notably after parturition and ovariotomy. He believes that the blood-poisoning after gunshot wounds of the peritoneum is consequent upon the pent-up, red, sero-fibrinous exudation which traumatic peritonitis invariably produces in abundance, and that if this effusion could be drained off as soon as it is formed septicemia might be prevented. In lacerated wounds of the abdominal walls, with exposure of the cavity, protrusion of the contents and the introduction of foreign matter into the cavity are nothing like so mortal. In all these cases the nature of the wound prevents union by the first intention, and drainage of abdominal effusions is effected. In the fifty-nine cases of recovery after penetrating wounds of the large intestine fifty-five were perforating wounds, the large aperture of exit being usually on the posterior surface of the body, dependent and facilitating drainage. In one of the four instances of recovery in simple penetrating shot-wound of the large bowel, the edges of the opening in the bowel were fastened to the wound in the abdominal wall, and in this, as well as in the other three cases, fecal fistulae were formed. Shot-wounds of the pelvis are nothing like so fatal as wounds of the peritoneum higher up. Unless accompanied by grave visceral lesion, three cases out of four of penetrating or perforating wounds of the pelvis recover. Can this fact be satisfactorily explained upon any other theory than that drainage in these wounds is almost unavoidable? Indeed in these cases we are taught to explore the wounds with the finger, remove loose pieces

of bone and foreign bodies, and keep the apertures of entrance and exit open, that free vent may be given to all inflammatory products; and if the size and position of the wound do not facilitate this we make the opening bigger and insert a drainage-tube. Spencer Wells attributes the fatality after ovariotomy to some form of pyemic fever or some form of blood-poisoning so often associated with peritonitis, and thinks the lesson taught by many successful ovariotomists of providing for the escape of inflammatory matter of great value, and one which should be profited by by the surgeon who treats gun-shot wounds of the peritoneum. Ovariotomists even go so far as to wash out the cavity when peritonitis exists and death from septicemia is imminent. In many of the cases of penetrating wounds of the peritoneum the ball passes obliquely through the abdominal wall, and the aperture shuts up like a valve, or if passing directly through the parietes the aperture of entrance contracts at once and closes. To all intents and purposes the cavity is hermetically sealed, and the missile, pieces of clothing, blood from wounded vessels, fecal effusion if the intestine is wounded, and inflammatory products are all hopelessly imprisoned there. Can it be wondered that such wounds are fatal? In no other gun-shot wounds of cavities do we allow the wounds of entrance and exit to be closed. Who would think of shutting up the opening in gun-shot wound of the knee-joint? During the late war the plan of hermetically sealing up wounds of the pleura—a structure analogous to the peritoneum—proved most disastrous. In gun-shot wounds of the chest involving the serous membrane we keep the wound patent, and if not dependent we do not hesitate, when effusion takes place, to make a counter-opening with a knife or trocar, and sometimes to flush out the cavity with detergent and antiseptic lotions. In view of these facts the writer ventures to advocate operative interference in gun-shot penetrating wounds of the peritoneum with intestinal injury, in penetrating wounds of the peritoneum with any visceral lesion, and similar cases without visceral injury. The wounds in the abdominal walls should be enlarged, or the linea alba opened freely enough to allow a thorough inspection of the injured parts. Hemorrhage should be arrested. If intestinal wounds exist they should be closed with animal ligatures, trimming their edges first if they are lacerated and ragged. Blood and all other extraneous matters should be carefully removed, and then provision made for drainage. If the wound of entrance is dependent, drainage may be secured by keeping this open. If the wound is a perforating one, and the aperture of exit dependent, the patency of this should be maintained, and, if necessary, a drainage-tube of glass or other material introduced. If there is no wound

of exit, and the wound of entrance is not dependent, then a dependent counter-opening should be made and kept open with a drainage-tube. If it is urged that the means suggested are desperate, it can be said in reply that the evil is desperate enough to justify the means.

Dr. Charles A. Leale, of New York, read a paper on labial carbuncle or malignant pustule of the lip. His method of treatment is to make a free incision outward and downward along the course of the fibers of the orbicularis oris muscle, extending the cut each way in a line until all the diseased tissue has been passed, taking care not to go through the mucous membrane lining the lip, to which extent the disease rarely extends; then with a fine piece of ivory or wood, with its ends covered with cotton, thoroughly apply to all the diseased parts and cut surface the chemically pure nitric acid. This is pressed with sufficient force into all the diseased parts so that every little pocket of pus is reached and the intervening membranes destroyed, which would otherwise be left to slough off and continue the septic or purulent infection. By this time the nervous and constitutional systems are very much depressed, and for the relief of the former and pain he gives morphia *pro re nata*, and to overcome the blood-poisoning whisky is given liberally, largely diluted with water. On some occasions he has had to apply the acid on the second or third day, or until all the poison has been rendered inert. His subsequent treatment is by the open-wound method, applying ungu. bals. Peru gently on lint and giving the patient the most nutritious diet and restorative tonics. Dr. Leale claims that by this treatment all the little canals making the cut surface appear like a sieve are reached, and that the entire poisonous mass is kept within circumscribed boundaries, and the absorbed poisons, by sustaining the system, are eliminated. In the early part of the treatment a full dose of sulphate of magnesia largely diluted in water is given. As a rule, it will be found that on the third or fourth days after the incision and the first application of the acid all danger will have subsided and the convalescence will steadily progress. But in some instances we may have acute mania from cerebral meningitis or erysipelas—the former to be treated by large hypodermic injections of morphia, and the latter, when possible to be retained, the cooling lotion of lead and opium.

Dr. Post stated that the subject was a most important one. He thought that when we see the patients early with malignant pustule a large proportion can be saved. He usually operated by cutting through the vermillion border of the lip.

Can we make a Positive Diagnosis of Pregnancy previous to the Occurrence of the Audible Sounds of the Fetal Heart and the Detec-

tion of the Fetal Movements? was the subject of a paper by Dr. Joseph Tabor Johnson, of Washington, D. C. It is claimed that in the softened condition of the cervix uteri and the pinkish color and increased temperature of the vagina we have quite positive diagnostic evidence of pregnancy. It is admitted that the only positive and indisputable signs are determined by auscultation, ballottement, and fetal movements; but these signs are not usually present in the first half of pregnancy. The presence of kiesteine in the urine, milk in the breast, the odor of vernix caseosa upon the finger as it is withdrawn from the vagina after a digital examination, the smooth condition of the anterior wall of the vagina and anterior cul-de-sac, associated with a pinkish-purple color of the vaginal mucous membrane, the placental souffle, the existence of gravidin in the urine, the presence of certain caseous elements resembling milk in the urine, were all passed in review as diagnostic signs of pregnancy, but no definitely-stated conclusion was arrived at.

Dr. R. Beverly Cole, of San Francisco, California, stated that there were three physical signs of pregnancy which he relied chiefly upon, viz: 1. Placental souffle; 2. Pulsation of the cord; and 3. The sounds of the fetal heart. He regarded the last as the best and most reliable of them all. Dr. Cole thought no signs positive enough generally to justify one in giving *decided* opinions when consulted on this point.

Dr. Albert H. Smith, of Philadelphia, thought placental souffle the most unreliable of the signs mentioned by Dr. Cole. Liked the bi-manual method best of all.

Dr. Paul F. Mundé said his favorite method was the bi-manual. He thought Dr. Smith had touched the key-note in making this statement. He thought that this method, taken with the other signs usually associated, would enable one to make out a case better than any other methods he knew of.

Dr. Alex. Dunlap, of Ohio, said his method was the bi-manual. The presence of fibroids may sometimes mislead, as they enlarge the womb, but they are generally hard when small, sometimes soft and dropical when large, and rarely symmetrical. These points he thought it well to notice. Sanious discharge from the os is strong evidence of intra-uterine fibroid.

Dr. James M. Scott, of St. Louis, asked if it was not difficult to use the bi-manual method on a fleshy patient, which was answered in the affirmative.

Prof. G. M. B. Maughes, of St. Louis, thought that we have an almost certain method in the bi-manual.

Prof. A. F. Erich, of Baltimore, thought the thermometric in-

dications in the os uteri would prove of great value as an aid in diagnosis.

Dr. Whittaker, of Cincinnati, read a paper on The Treatment of Diphtheria, taking the ground that diphtheria was first a local and afterward a general disease; that it is only when the epithelial barrier is broken down that the blood and the body become infested. The essayist maintained that the poison passes over into the blood little by little, new quantities reinforcing the first installments until the blood is super-saturated with the disease. The treatment therefore resolved itself into treatment of the poison at the local depot and relative neutralization of virus in the blood. The efficacy of the antiseptics, quinia, salicylic acid, and the benzoates, was next detected with the experiments with the latter of Buckholtz and Graham Brown, whereby it was shown that saturation of the blood with the benzoates renders inoculation impossible. The essayist next maintained that although we could not kill the germs of the disease in the throat, we could so condense its mucous membrane as to make it a dam to the influx of the disease. To effect this purpose the essayist recommended the persulphate of iron in full strength applied well up behind the velum palati. Though the persulphate of iron was one of the oldest recommendations of practical medicine in the treatment, the author believed its occasional inefficacy and present comparative disuse to be due to the dilution of the solution. The author knew very well the fallacy of basing conclusions upon experience, and mentioned the fact that he had never had a fatal case since the use of this treatment, and stated that he had never seen any accidents incidental to the treatment.

The following officers were elected for the ensuing year: President, Dr. T. J. Woodward, U. S. A.; Vice-presidents, Drs. P. O. Harper of Arkansas, L. Conner of Michigan, Eugene Gressom of North Carolina, and Hunter McGuire of Virginia; Secretary, Dr. Wm. B. Atkinson of Pennsylvania; Treasurer, Dr. R. J. Dunglison of Pennsylvania; Librarian, Dr. Wm. Lee of Washington; To fill vacancies in the Medical Council, Drs. S. N. Benham of Pennsylvania, J. M. Toner of Washington, D. A. Linthecum of Arkansas, William Brodie of Michigan, H. D. Holton of Vermont, A. B. Sloan of Missouri, and R. B. Cole of California.

St. Paul, Minnesota, was selected as the place for the next annual meeting, and Dr. Stone was appointed chairman of the Local Committee of Arrangements.

Personal.—Dr. Joseph J. Woodward, the newly elected president, is from Washington, D. C. He was born in Philadelphia in 1832. He was educated at the Philadelphia Central High School, from which

he received the degree of A.B. in 1850 and that of A.M. in 1855. After receiving his first degree he began the study of medicine, and graduated from the University of Pennsylvania in the spring of 1853. For some time thereafter he practiced his profession in Philadelphia, acting during that time as examiner and teacher upon microscopical and pathological anatomy. He entered the army and rose rapidly, and is now the chief assistant in the surgeon-general's bureau at Washington, with the rank of lieutenant-colonel. He is the medical editor of the *Medical and Surgical History of the Rebellion*.

Dr. P. O. Hooper, of Little Rock, Ark., the first vice-president, was born in that city October 11, 1833. He was educated at Nashville, Tenn., and graduated in 1856 from Jefferson Medical College, Philadelphia. He is a member of the Arkansas State Medical Society and of the College of Physicians and Surgeons of Little Rock, and is also a permanent member of the American Medical Association. He is president of the Board of Trustees of the Arkansas State Lunatic Asylum. During the war he held the position of surgeon in the Confederate Army, and was president of the Army Medical Board for the examination of applicants for position in the medical department of the Confederate Army.

AMERICAN MEDICAL COLLEGE ASSOCIATION.—This body met in Richmond, Va., May 5th, with quite a full attendance. The meeting was called to order by the president, Professor S. D. Gross, M.D., of Philadelphia, Professor Leartus Connor, of Detroit, acting as secretary. The following officers were elected for the ensuing year: President, Professor J. M. Bodine, of the Medical Department of the University of Louisville, Ky.; Vice-president, Professor W. T. Briggs, of Nashville, Tenn.; Secretary and Treasurer, Professor Leartus Connor, of Detroit, Mich.

Secretary Connor's report was then presented and received. It shows an increase of two in the active membership of the Association since the last annual meeting. From the reports of the several colleges made to the secretary it appears that these institutions had conformed more universally and completely with the requirements of the Association than heretofore, and that every thing pertaining to their connection with the body was entirely satisfactory.

The report of the Committee on Medical Colleges showed

that sixty-four catalogues of colleges had been examined, and that only sixteen of them had failed to come up to the Association's requirements in the matter of graduation. It also appeared that twenty-two of the colleges had surpassed these requirements in one or more of the three following particulars: First, matriculation examinations; second, nine months' regular attendance; third, the three regular terms required.

